IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division

ROBERT FLICK,

Plaintiff,

In his Individual Capacity and on behalf of the Estate of Loraine Boyne, Deceased

v.

CSRA, INC.

Defendant.

SERVE AT:
CT Corporation System
4701 Cox Rd., Suite 285
Glen Allen, VA 23060

CASE NO. _____

COMPLAINT

COMES NOW your Petitioner, **ROBERT FLICK,** by counsel, and in support of his Complaint respectfully states as follows:

THE PARTIES

1. Loraine Boyne, deceased, was a senior manager employed by Computer Sciences Corporation "CSC" for many years until her termination in January, 2016. She resided at 6842 McFall Place, McLean, VA 22101, in Fairfax County.

2. Effective November 30, 2015, the former North American Public Sector business division of CSC split off and merged with SRA International, Inc., to form the independent company CSRA, Inc. CSRA Inc. is a foreign corporation doing business in Virginia and registered with the Virginia State Corporation Commission.

registered with the Virginia State Corporation Commission.

3. Robert Flick is the widower of Loraine Boyne, and formerly resided at 6842 McFall Place, McLean, VA 22101, in Fairfax County. He now resides at 107 Deer Hill Ct., Stephens City, Virginia 22655.

JURISDICTION AND VENUE

4. This court has jurisdiction over this matter under U.S.C. 28 Section 1331.

5. Venue is proper in this Court under U.S.C. 28 Section 1391.

FACTUAL BACKGROUND

6. Ms. Boyne worked in the section of CSC that did business as Computer Sciences Government Corporation, or "CSGov."

7. Effective November 30, 2015, the former North American Public Sector business division of CSC split off and merged with SRA International, Inc., to form the independent company CSRA, Inc.

8. As part of her employment agreement with CSC/CSRA (the "Company"), the Company agreed to provide certain employee benefits, among them a life insurance benefit by which the Company would pay for life insurance for Ms. Boyne under the terms of a group life insurance policy. Specifically, the Company sponsored the CSC Group Insurance Plans, which included life insurance benefits underwritten by Aetna Life Insurance Company of Hartford ("Aetna") (Exhibit 1). The Company also sponsored the CSRA Inc. Fully-Insured Employee Welfare Benefits Plan, which included life insurance benefits underwritten by Hartford Life and Accident Insurance Company ("Hartford") (Exhibit 2).

9. Included in Ms. Boyne's employee benefits was the opportunity for Ms. Boyne to pay an additional premium under the Hartford policy for a higher life insurance benefit.

10. By agreeing to provide the life insurance benefit under the Hartford policy, the Company agreed to provide Ms. Boyne with the ability to continue life insurance coverage after any termination of her employment, subject to the terms of the Hartford policy permitting coverage continuation (and subject to Ms. Boyne's eligibility under the terms of that policy to continue coverage).

11. During her time working for the Company, Ms. Boyne elected to utilize the employee life insurance benefit, and participated as a named insured under the Hartford policy. She also elected to utilize the benefit of paying an additional premium under the Aetna policy for a supplemental life insurance benefit.

12. The Company paid the premium on the policy for Ms. Boyne's base life insurance coverage, and deducted the premium for Ms. Boyne's supplemental life insurance coverage from her paychecks. The Company administered the policy and communicated with the insurer. Ms. Boyne did not participate in the policy's administration or communicate directly with the insurer. She did not have a copy of the policy.

13. Ms. Boyne's base life insurance coverage was one times her annual salary. Her supplemental life insurance coverage was an additional two times her annual salary. Her annual salary was approximately $149,000.00.

14. Robert Flick, Ms. Boyne's husband, was the sole beneficiary of her life insurance.

15. Mr. Flick was therefore a third-party beneficiary of the Company's agreement with Ms. Boyne to provide life insurance for Ms. Boyne under the terms of the Hartford policy, and the Company's agreement to provide Ms. Boyne with the ability to continue life insurance coverage after any termination of her employment, subject to the terms of the Hartford policy permitting coverage continuation (and Ms. Boyne's eligibility under the terms of that policy to

continue coverage).

16. Ms. Boyne was diagnosed with ovarian cancer in late 2014, and went on short-term disability, then long-term disability, both through disability insurance policies provided by her employer and administered by Aetna Insurance.

17. In December, 2015, Ms. Boyne had series of small strokes, then a larger stroke in January 2016 that left her unable to communicate.

18. By January 2016, Ms. Boyne had been on long-term disability for a year, and in accordance with the Company's employment policies, she was terminated as an employee.

19. In the fall of 2015, knowing that she would be terminated after she had been on long-term disability for a year, Ms. Boyne inquired with the Company about maintaining her life insurance coverage after her termination, and was told that it would be maintained. In that time period, she told Mr. Flick that she had been informed by the Company that her life insurance coverage would be maintained after her termination.

20. Based upon the fact that the Company, not Ms. Boyne, had administered the policy, Ms. Boyne and Mr. Flick reasonably relied on the Company's representation and did not contact the life insurer directly to confirm that her coverage would be maintained.

21. The Hartford policy had three options for continuing coverage after termination. The first option was known as "Waiver of Premium." *See* Exhibit 2, p. 23. Under this provision, an employee who was disabled and who qualified for Waiver of Premium had the right to continue coverage without paying a premium. The amount of continued coverage was the amount in force on the date the individual ceased to be an active employee. The Hartford policy had eligibility requirements for this Waiver of Premium option, including the requirement that the insured was less than 60 years old when he/she became disabled.

22. The second option was "Portability." *See* Exhibit 2, p. 27-28. The Hartford policy allowed an employee to continue coverage after termination by submitting a portability application within 31 days of termination and continuing to pay the premium.

23. The third option was "Conversion." *See* Exhibit 2, p. 26-27. The Hartford policy allowed an employee to continue coverage after termination by applying to the insurer for an individual life insurance policy called a "conversion policy," and the individual had to pay the premiums. The application had to be completed within 31 days of the employee's termination.

24. In addition, an employee could not apply for the Portability or Conversion options if they had elected the Waiver of Premium option and were eligible. The Hartford policy stated that if the Waiver of Premium option was denied due to lack of eligibility, the individual could then continue coverage under the Portability benefit or convert coverage using the Conversion benefit.

25. The Aetna policy had two options for continuing coverage after termination. The first option was known as "Life Insurance Portability." *See* Exhibit 1, p. 12. The Aetna policy allowed an employee to continue coverage after termination by submitting a portability application within 31 days of termination and continuing to pay the premium. The second option was "Converting to an Individual Life Insurance Policy." *See* Exhibit 1, p. 18. The Aetna policy allowed an employee to continue coverage after termination by applying to the insurer for an individual life insurance policy called a "conversion policy," and the individual had to pay the premiums. The application had to be completed within 31 days of the employee's termination.

26. As part of the termination process, the Company sent Ms. Boyne a document, dated January 15, 2016, and titled "Your Benefits Upon Termination of Employment After a 12-Month Leave of Absence" (Exhibit 3). The termination date was identified as January 23, 2016.

The document stated that, in regard to Ms. Boyne's Employee Basic Life Insurance Coverage: "Carrier has approved your Waiver of Premium Request for Basic Life coverage (No action is required from you for your Basic Life coverage."

27. This document confirmed what Ms. Boyne had been told by the Company when she inquired about continuing her life insurance coverage after termination: namely, that it would be maintained.

28. Based upon the fact that the Company, not Ms. Boyne, had administered the policy, Ms. Boyne and Mr. Flick reasonably relied on the Company's representation in the January 15, 2016 document, and did not contact the life insurer directly to confirm the information in that document that "Carrier has approved your Waiver of Premium Request for Basic Life coverage."

29. In reliance on this representation from the Company, Ms. Boyne and Mr. Flick took no action to pursue the Portability or Conversion options for continuing Ms. Boyne's life insurance coverage after her termination. They also did not pay premiums on the policies. They reasonably believed, based on the representation from the Company, that the policies were continued.

30. It was reasonably foreseeable to the Company that Ms. Boyne and Mr. Flick would rely on the January 15, 2016 document and take no action to ensure the continuation of Ms. Boyne's life insurance coverage.

31. The Company did not send any documents to Ms. Boyne regarding the Portability or Conversion options for her life insurance policy, or any material regarding application for these options. Ms. Boyne did not receive any invoices for premiums after her termination, either from the Company or from the insurer.

32. After Ms. Boyne passed away on August 28, 2016, Mr. Flick, on behalf of her Estate and as beneficiary of the policy, contacted the Company to determine how to claim Ms. Boyne's life insurance benefit. He was directed to Aetna Life Insurance Company. Aetna then informed Mr. Flick that Ms. Boyne did not qualify for the Waiver of Premium provision because she was over 60 years old when she became disabled. (Exhibit 4).[1] The life insurance benefit under the policy was not paid. Mr. Flick has subsequently learned that (unlike the Hartford policy) the Aetna policy did not have a Waiver of Premium provision, so it is unclear as to whether Aetna's response related to the Hartford policy or the Aetna policy.

33. Had Mr. Flick and Ms. Boyne known that Ms. Boyne did not qualify for the Waiver of Premium provision under the Hartford policy, Ms. Boyne would have instead submitted a portability or conversion application under the Hartford and Aetna policies in order to continue her coverage after her termination.

34. Had Ms. Boyne submitted a portability or conversion application under the Hartford or Aetna policies, she would have been eligible for continuation of her coverage.

35. The Company's representation in the January 15, 2016 document that "Carrier has approved your Waiver of Premium Request for Basic Life coverage (No action is required from you for your Basic Life coverage)" was false and a misrepresentation of a material fact.

36. At the time the Company sent Ms. Boyne the January 15, 2016 document, the Company was aware, or should reasonably have been aware, that Ms. Boyne did not qualify for

[1] Plaintiff does not know why the Company directed him to Aetna. At the time he contacted the Company, this made sense to him, as he understood Aetna to be the life insurer under the Company's group plan. It now appears that the group plan policy in question was underwritten by Hartford, and the supplemental policy was issued by Aetna. Only the Hartford policy contains a waiver of premium provision. The Aetna policy contains "Portability" and "Conversion" provisions similar to those in the Hartford policy. However, Aetna's response letter referenced the "Waiver of Premium" provision contained in the Hartford policy, and stated that this policy was actually issued by Aetna (though it now appears it was issued by Hartford). This response from Aetna led Mr. Flick to believe that the Waiver of Premium provision was applicable to the Aetna policy.

the Waiver of Premium provision.

37. At the time the Company sent Ms. Boyne the January 15, 2016 document, the Company was aware that Mr. Flick was the sole beneficiary of Ms. Boyne's life insurance.

38. Ms. Boyne and Mr. Flick's reliance on the Company's statement in the January 15, 2016 document was detrimental to them because it cost them the ability to pursue the other coverage continuation possibilities provided in the Hartford and Aetna policies, which ultimately thwarted their intent to maintain life insurance coverage for Ms. Boyne and cost Mr. Flick the ability to recover Ms. Boyne's life insurance benefits under the policies.

39. Mr. Flick filed suit against the Company in Fairfax County, Virginia, on August 15, 2017. The case was removed to this Court then dismissed without prejudice by order of this Court on December 5, 2017 due to pre-emption by ERISA and failure to exhaust administrative remedies.

40. In early 2018, Mr. Flick made several calls to attempt to learn how to submit a claim for life insurance benefits under the Hartford policy. On February 5, 2018, he called Hartford, and was told the policy was active, but was a group policy and Hartford did not have records for individuals, so the Company had to initiate the claim. On February 12, 2018, he called the Company's benefits hotline and spoke to a representative who took information and told him she would open a claim and call Mr. Flick back, but he never heard back. On March 1, 2018, he called the Company's benefits hotline and spoke to a representative who took information and told Mr. Flick she would call him back, but he never heard back. On March 6, 2018, he called the Company's benefits hotline and spoke to a representative who took information and told Mr. Flick that he needed to send an email to the Company's Benefits department. On March 18, 2018, as directed in the last call, he sent an email to the Benefits

department of the Company regarding the claim on Ms. Boyne's life insurance policy. (Exhibit 5). Mr. Flick received an automated response and then followed up on April 12, 2018. (Exhibit 6). He received another automated response. (Exhibit 7). On May 1, 2018, Mr. Flick sent another follow-up email. (Exhibit 8). He received another automated response. (Exhibit 9). On June 28, 2018, Mr. Flick then sent the same email from March 18, 2018 to the CSRAhealthandwellness@willistowerswatson.com email address contained in the automatic replies from the Company (Exhibit 10), and received an email referring him back to the Company email address. (Exhibit 11). On November 23, counsel for Mr. Flick sent a lengthy email to the Benefits department of the Company regarding the claim on Ms. Boyne's life insurance policy. (Exhibit 12). Another automated response was received. (Exhibit 13).

41. None of Mr. Flick's calls or emails have resulted in a substantive response from the Company. The Company has not directed Mr. Flick to an administrative claims process to submit a claim for benefits or appeal an adverse decision.

COUNT I – RECOVERY OF BENEFITS UNDER FEDERAL ERISA STATUTE

42. Paragraphs 1-41 are incorporated as if fully re-stated herein.

43. The Company provided Ms. Boyne with an employee life insurance benefit that included the life insurance policy's provisions for maintenance of coverage after her termination. It also provided her with the option to purchase supplemental life insurance coverage under a group plan, which Ms. Boyne did. That policy also had provisions for maintenance of coverage after her termination.

44. Mr. Flick was the beneficiary of the policies.

45. The Company wrongly told Ms. Boyne and Mr. Flick that her life insurance coverage would be maintained after termination, that Ms. Boyne had been "approved" for the

Waiver of Premium provision of the life insurance policy, and that "no action [was] required" for the continuation of her coverage after her termination

46. As a reasonably foreseeable result of the Company's misrepresentations, Ms. Boyne and Mr. Flick relied on what the Company told them and took no action to pursue the Portability or Conversion options for continuing Ms. Boyne's life insurance coverage under the policies after her termination.

47. As a result of not submitting applications for Portability or Conversion under the life insurance policies, Ms. Boyne and Mr. Flick were damaged in that their intent to maintain life insurance coverage for Ms. Boyne was thwarted, and Mr. Flick received no life insurance benefit upon his wife's death.

48. The federal ERISA statute provides at 29 U.S.C. 1132(a)(1)(b) that a beneficiary may bring an action "to recover benefits due to him under the terms of his plan."

49. In this case, through its misrepresentations, the Company deprived Mr. Flick, as a beneficiary of the policies, of the benefits of those policies due to him under the terms of Ms. Boyne's plan.

50. Plaintiff has repeatedly contacted the Company in an effort to resolve the matter, but has received no response. As such, it is fair to characterize the administrative remedy as exhausted or futile.

51. Therefore, Plaintiff is entitled to damages in the amount of the life insurance benefit in Ms. Boyne's life insurance policies, which is three times her annual salary, or $447,000.00.

52. Further, Plaintiff is entitled to his attorneys' fees and costs pursuant to 29 U.S.C. 1132(g).

WHEREFORE, for the foregoing reasons and those that may be later discovered, your Plaintiff, by counsel, moves this Honorable Court to: (1) enter an Order awarding Plaintiff $447,000.00 in damages against Defendant, plus post-judgment interest; (2) award Plaintiff his attorneys' fees and costs; and (3) award such other and further relief as this Honorable Court deems just and appropriate.

TRIAL BY JURY IS HEREBY DEMANDED

Respectfully submitted,

ROBERT FLICK,
By Counsel,

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BENEFIT PLAN

Prepared Exclusively for CSC and its Affiliated and Participating Employers

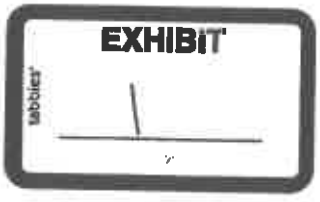
Basic and Supplemental Life Insurance and Dependents Life Insurance
For regular full time employees on U.S. payroll

SAP Codes: LB02, LB03, LS04, LS05

What Your Plan Covers and How Benefits are Paid

Aetna Life Insurance Company
Booklet-Certificate

This Booklet-Certificate is part of the Group Insurance Policy between Aetna Life Insurance Company and the Policyholder



aetna℠

Table of Contents

*Defines the Terms Shown in Bold Type in the Text of This Document.

Preface *(GR-9N-02-005-01 VA)*

Aetna Life Insurance Company (ALIC) is pleased to provide you with this *Booklet-Certificate*. Read this *Booklet-Certificate* carefully. The plan is underwritten by Aetna Life Insurance Company of Hartford, Connecticut (referred to as **Aetna**).

This *Booklet-Certificate* is part of the *Group Insurance Policy* between Aetna Life Insurance Company and the Policyholder. The *Group Insurance Policy* determines the terms and conditions of coverage, **Aetna** agrees with the Policyholder to provide coverage in accordance with the conditions, rights, and privileges as set forth in this *Booklet-Certificate*. The Policyholder selects the products and benefit levels under the plan. A person covered under this plan and their covered dependents are subject to all the conditions and provisions of the *Group Insurance Policy*.

The *Booklet-Certificate* describes the rights and obligations of you and **Aetna**, what the plan covers and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this *Booklet-Certificate*. Your *Booklet-Certificate* includes the *Schedule of Benefits* and any amendments or riders.

If you become insured, this *Booklet-Certificate* becomes your *Certificate of Coverage* under the *Group Insurance Policy*, and it replaces and supersedes all certificates describing similar coverage that **Aetna** previously issued to you.

Group Policyholder:	Computer Sciences Corporation
Group Policy Number:	GP-838912
Effective Date:	January 1, 2012
Issue Date:	June 11, 2012
Booklet-Certificate Number:	8 - CSC and its Affiliated and Participating Employers

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Important Information Regarding Availability of Coverage *(GR-9N-02-005-02 VA)*

No services are covered under this *Booklet-Certificate* in the absence of payment of current premiums subject to the *Grace Period* and the *Premium* section of the *Group Insurance Policy*.

Unless specifically provided in any applicable termination or continuation of coverage provision described in this *Booklet-Certificate* or under the terms of the *Group Insurance Policy*, the plan does not pay benefits for a loss or claim for a health care, medical or dental care expense incurred before coverage starts under this plan.

This plan will not pay any benefits for any claims, or expenses incurred after the date this plan terminates.

This provision applies even if the loss, or expense, was incurred because of an **injury** or **illness** that occurred, began or existed while coverage was in effect.

Please refer to the sections, "*Termination of Coverage (Extension of Benefits)*" and "*Continuation of Coverage*" for more details about these provisions.

Benefits may be modified during the term of this plan as specifically provided under the terms of the *Group Insurance Policy* or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any expenses incurred for services or supplies furnished on or after the effective date of the plan modification. There is no vested right to receive any benefits described in the *Group Insurance Policy* or in this *Booklet-Certificate* beyond the date of termination or renewal including if the service or supply is furnished on or after the effective date of the plan modification, but prior to your receipt of amended plan documents.

Coverage for You and Your Dependents (GR-9N-02-005-01 VA)

Life Insurance Coverage *(GR-9N-02-015-01)*

A benefit is payable if you lose your life or a covered dependent loses his or her life while coverage is in effect. Please refer to the *Life Insurance* and *Life Insurance For Your Dependents* sections for more details about covered losses.

Eligibility, Enrollment and Effective Date of Your Coverage

(GR-9N-29-005-02 VA)

Who Can Be Covered

How and When to Enroll

When Your Coverage Begins

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, 'you', 'your' and 'yours' means you and your covered dependents to whom this *Booklet-Certificate* is issued and whose insurance is in force under the terms of this group insurance policy.

Who is Eligible

Your employer determines the criteria that are used to define the eligible class for coverage under this plan. Such criteria are based solely upon the conditions related to your employment. **Aetna** will rely upon the representation of the employer as to your eligibility for coverage under this plan and as to any fact concerning such eligibility.

Employees

You are eligible for coverage under this plan if you are **actively at work** and:

- You are in an eligible class, as defined below;
- You have completed any probationary period required by the policyholder; and
- You have reached your eligibility date.

Determining if You Are in an Eligible Class *(GR-9N-29-005-02 VA)*

You are in an eligible class of:

- All regular full time employees on U.S. payroll, including those employees covered by a formal sales incentive plan, who work for an employer that offers this benefit to its employees and are not covered under a collective bargaining agreement, unless the agreement specifically includes participation in this plan's features.

Eligibility for Life Insurance if Permanently and Totally Disabled *(GR-9N-29-005-04 VA)*

The following applies to Supplemental Life Insurance:

You may remain eligible for Life Insurance coverage, subject to change or termination as provided elsewhere in the group contract, if your Employer determines that you have become permanently and totally disabled, if the total disability starts:

- while you are insured; and
- on or after the date this subsection applies to you; and
- before you retire; and
- your employer continues premium payments for this coverage.

This eligibility ceases the date your Employer determines that you are no longer permanently and totally disabled.

Report a disease or injury to your Employer as soon as you can. Your Employer will help you determine if you qualify.

Determining When You Become Eligible *(GR-9N-29-005-02 VA)*

You become eligible for the plan on your eligibility date, which is determined as follows.

On the Effective Date of the Plan

If you are in an eligible class on the effective date of this plan, your coverage eligibility date is the effective date of the plan.

After the Effective Date of the Plan

If you are hired after the effective date of this plan, your coverage eligibility date is the date you are hired.

If you enter an eligible class after the effective date of this plan, your coverage eligibility date is the date you enter the eligible class.

Obtaining Coverage for Dependents *(GR-9N-29-010-02 VA)*

Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse; and
- Your dependent children.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

Coverage for Dependent Children *(GR-9N-29-010-02 VA)*

To be eligible, a dependent child must be:

- Unmarried; and
- At least 14 days old, but under age 19; or
- Under age 24, as long as he or she is a full-time student at an accredited institution of higher education and solely depends on your support*.

* Note: Proof of full-time student status is required each year. This means that the child is enrolled as an undergraduate student with a total course load of at least 12 credits or is enrolled as a graduate student with a total course load of at least 9 credits.

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

Important Reminder

Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

How and When to Enroll *(GR-9N 29-015 02 VA)*

Enrollment

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner determined by **Aetna** and your employer. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents including any evidence of good health. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, and will advise you of the required amount. Your contributions will be deducted from your pay. Remember plan contributions are subject to change.

Your contributions may be reduced due to Aetna's failure to provide agreed upon service levels. Such service levels are guaranteed by Aetna and agreed to in writing by Aetna and your Employer. See your employer for details.

You will need to enroll within 30 days of your eligibility date.

For Dependent Life Insurance, newborns are automatically covered from the 14th day until the 31st day after birth. To continue coverage after 30days, you will need to complete a change form and return it to your employer within the 31-day enrollment period.

Evidence of Good Health *(GR-9N 29-015 02 VA)*

You must provide evidence of good health that is satisfactory to **Aetna** if:

- You request to enroll more than 30 days after your eligibility date.

If you are required to submit evidence of good health, you must:

- Complete and sign a health and medical history form provided by **Aetna**;
- Submit to a medical examination, if requested;
- Provide any additional information that **Aetna** may require including attending **physician's** statements; and
- Furnish all such evidence at your own expense.

When Your Coverage Begins *(GR-9N-29-025-01 VA)*

Your Effective Date of Coverage

Your coverage takes effect on the later of:

- The date you are eligible for coverage; and
- The date you return your completed enrollment information; and
- The date any required evidence of good health is approved by Aetna; and
- The date your required contribution is received by **Aetna.**

Active Work Rule: If you happen to be ill or injured and away from work on the date your coverage would take effect, the coverage will not take effect until you return to full-time work for one full day. This rule also applies to an increase in your coverage.

Your Dependent's Effective Date of Coverage

Your dependent's coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan by then.

Note: New dependents need to be reported to **Aetna** within 30 days because they may affect your contributions. If you do not report a new dependent within 30 days of his or her eligibility date, evidence of good health may be required.

Your Life Insurance Plan

(GR-9N 03-005 01-VA)

Life insurance is an important component of your financial planning. The Life Insurance Plan pays a benefit to your beneficiary if you die while covered by the plan. Refer to the *Schedule of Life Insurance Benefits* for information about the plan's benefit. This section will help you understand the following:

- Naming a Beneficiary
- Payment of Benefits
- How to convert your coverage, and
- How to change coverage amounts

How the Plan Works *(GR-9N 03-005 01-VA)*

Naming Your Beneficiary

A beneficiary is the person you designate to receive life benefits if you should die while you are covered. You may name anyone you wish as your beneficiary. You may name more than one beneficiary. You will need to complete a beneficiary designation form, which you can get from your employer.

If you name more than one primary beneficiary, the life insurance benefits will be paid out equally unless you stipulate otherwise on the form. If you name more than one primary beneficiary and the amount or percentage of the payment to your primary beneficiaries does not equal 100% of your life insurance amount, the difference will be paid equally to your named primary beneficiaries.

You may change your beneficiary choice at any time by completing a new beneficiary designation form. Send the completed form to your employer or to **Aetna**. The beneficiary change will be effective on the date you sign a new beneficiary designation form.

Prior to your death, you are the only person who can name or change your beneficiary. No other person may change your beneficiary on your behalf, including, but not limited to, any agent under power of attorney, whether durable or non-durable, or other power of appointment.

Aetna pays life insurance benefits in accordance with the beneficiary designation Computer Sciences Corporation has on record. Any payment made before **Aetna** receives your request for a beneficiary change will be made to your previously designated beneficiary. **Aetna** will be fully discharged of its duties as to any payment made, if the payment is made before **Aetna** receives notification of a change in beneficiary.

If Your Beneficiary Dies Before You

If one of your named primary beneficiaries dies before you, his or her share will be payable in equal shares to any other named primary beneficiaries who survive you. If you have named a contingent beneficiary, your contingent beneficiary will only be paid if all primary beneficiaries die before you.

If you have not named a primary or contingent beneficiary, or if the person you have named dies before you, payment will be made as follows to those who survive you:

- Your spouse.
- If there is no spouse, in equal shares to your children.
- If there is no spouse, or you have no children, to your parents, equally or to the survivor.
- If there is no spouse, or you have no children, or parents, in equal shares to your brothers and sisters.
- If none of the above survives, to your executors or administrators.

If Your Beneficiary Is a Minor

The method of payment will differ if your beneficiary is:

- A minor; or
- Legally unable to give a valid release for payment of any Life Insurance benefit, in **Aetna's** opinion.

Aetna will issue (as permitted by applicable state law) the life insurance payment to:

- The guardian of your beneficiary's estate; or
- The custodian of the beneficiary's estate under the Uniform Transfer to Minors Act; or
- An adult caretaker/legal guardian.

Aetna will be fully discharged of its duties as to the extent of the payment made. **Aetna** is not responsible for how the payment is used.

Conversion Benefit *(GR-9N 03-010 01)*

A life conversion option may be available without a medical exam if you apply for it within 31 days of your loss of eligibility under the plan. For more information about the conversion provision, refer to the *Conversion* section.

Permanent and Total Disability Benefit *(GR-9N-03-035-01)*

The following applies to Basic Life Insurance:

In the event you become disabled as the result of a disease or **injury**, you may be eligible for a permanent and total disability benefit if **Aetna** determines that you are permanently and totally disabled. You will not have to make any further contributions for life insurance coverage, and your employer will not have to make premium payments on your behalf.

If you were insured for Dependent Life Insurance, you will have the option to convert their coverage when this section applies to you.

Permanently and Totally Disabled

You will be considered permanently and totally disabled under this plan if disease or **injury** prevents you from:

- Working at your own job or any other job for pay or profit; and
- Being able to work at any reasonable job. A "reasonable job" is any job for pay or profit which you are, or may reasonably become, qualified for by education, training, or experience.

Qualifying for the Permanent and Total Disability Benefit *(GR-9N 03-040 01)*

You must meet ***all*** of the following criteria to qualify for this benefit:

- You must be insured under this plan when you stop active work due to your disease or **injury**;
- You must be under age 60 when you stop active work; and
- You must be absent from active work for 6 consecutive months without interruption.

Stopping active work means the date you are no longer physically at your job performing the duties of your job.

You must give **Aetna** a written notice of claim for this extended benefit. **Aetna** must receive your notice within 12 months from the date you stop active work. If your written notice is not received within 12 months of the date you stop active work, you will not be eligible for this benefit extension.

You must furnish proof of your permanent and total disability upon request by **Aetna**. **Aetna** also has the right to have a **physician** examine you, at no cost to you. **Aetna** will use the information to help determine if you are permanently and totally disabled.

Amount of Benefit Payable *<(GR-9N 03-045 01)*

Your extended benefit will be equal to the amount you were insured for on the date your permanent and total disability began, however, coverage will be reduced as described in the section called *"When Life Insurance Coverage Amounts are Reduced."*

When the Permanent and Total Disability Benefit Cease *(GR-9N 03-050 01)*

This benefit extension will stop when the first of the following occurs:

- The date **Aetna** sends you a request (at the most recent address in its records) for:
  - An exam or proof that you are still permanently and totally disabled; and
  - You do not go for the exam or provide proof of your continued disability within 31 days of that date.
- The date you are able to work at any reasonable job;
- The date you begin working at any job for pay or profit;
- The date you retire;
- The date you reach the amended 1983 Social Security Normal Retirement Age. See the chart below.

Birth Year	Normal Retirement Age
Before 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 to 1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
After 1959	67

After your insurance has been extended continuously for 2 years, **Aetna** will not require an exam or proof more than once in a 12 month period.

You will be eligible to convert to an individual life insurance policy, as if your employment had ended, when this benefit extension ceases. Refer to the *Conversion* section for more details. However, if you become eligible for life insurance under any group policy within 31 days of the date this benefit extension ceases, conversion is not allowed.

Extended Death Benefit *(GR-9N 03-060 01)*

Aetna will pay your beneficiary the amount of life insurance that may be extended under the permanent and total disability feature. Your beneficiary must give **Aetna** proof that all of the following apply:

- Your life insurance premium payments ended while you were absent from work due to disease or **injury** and before **Aetna** received your written notice of claim for the permanent and total disability benefit;
- You were continuously absent from active work until the time of your death;
- Your death occurred no later than 12 months after premium payments stopped;
- You would have qualified for the permanent and total disability benefit except that:
  - You were not absent from work for 6 consecutive months without interruption; or
  - **Aetna** had not yet received or approved your claim for the permanent and total disability benefit.

Your beneficiary must give **Aetna** written notice of your death within 12 months of your death. If **Aetna** does not receive the notice, **Aetna** will not be obligated to pay this benefit.

When **Aetna** approves a claim for any benefit under this feature, the benefit will be in full settlement and satisfaction of **Aetna's** obligations. After you cease active work with your employer due to disease or **injury**, you must ensure that **Aetna** and your employer have current beneficiary information on file. If current beneficiary information is not sent to **Aetna** in writing, and, your employer has discontinued the Plan with **Aetna**, **Aetna** will have the right to rely on the most recent beneficiary information that **Aetna** has on file at the time of claim and will be fully discharged of its duties as to any payment made.

If you have an individual policy that was issued to you under the conversion privilege, your rights under this section may be restored only if you give up your conversion policy and do not make a claim for benefits under the conversion policy. Any premium already paid for the conversion policy will be returned to your beneficiary, minus any dividends or outstanding loans, on surrender of this policy.

Accelerated Death Benefit *(GR-9N 03-075 02-VA)*

The plan's Accelerated Death Benefit feature allows you to receive a partial life insurance benefit if you or your spouse are:

- Diagnosed with a terminal illness and not expected to survive more than the ADB Months; or
- Diagnosed with one of the following medical conditions:
  - Amyotrophic Lateral Sclerosis (Lou Gehrig's disease);
  - End stage heart, kidney, liver and/or pancreatic organ failure and you are not a transplant candidate;
  - A medical condition requiring artificial life support, without which you would die; or
  - A permanent neurological deficit resulting from a cerebral vascular accident (stroke) or a traumatic brain injury which are both expected to result in life-long confinement in a **hospital** or **skilled nursing facility.**

Important Reminder
You cannot request an Accelerated Death Benefit payment if you have assigned your life insurance benefits, or the life insurance benefits of your spouse.

The Amount of Accelerated Death Benefit

You can request up to the Accelerated Death Benefit percentage of the life insurance that is currently in effect for the person for whom you are making the request. The amount you request cannot be:

- Less than the Accelerated Death Benefit minimum; or
- More than the Accelerated Death Benefit maximum.

Please refer to the Schedule of Benefits.

You may request and receive an Accelerated Death Benefit under this plan only ***once*** on your own behalf, and only ***once*** on behalf of any spouse.

Requesting an Accelerated Death Benefit *(GR-9N 03-080 02)*

To request the Accelerated Death Benefit, you must complete and submit a request form to **Aetna**. The request form must include:

- A statement of the amount requested; and
- A **physician's** statement verifying that you are suffering from a non-correctable **terminal illness**, or, are suffering from one of the listed medical conditions that is expected to result in a drastically limited life span. The statement must also provide the following information:
  - All medical test results;
  - Laboratory reports; and
  - All supporting documentation and information on which the **physician's** statement is based.

Submit the form to **Aetna**. **Aetna** may, at its own expense, require you or your spouse to submit to an independent medical exam by a **physician** it chooses. **Aetna** will not process your Accelerated Death Benefit request until the exam has been completed and **Aetna** has received the results.

Aetna May Refuse Your Accelerated Death Benefit Request:

Aetna may stop processing your Accelerated Death Benefit request or refuse your Accelerated Death Benefit request if:

- The group policy terminates coverage for your eligible class before **Aetna** approves your Accelerated Death Benefit request (even if all or part of your life insurance coverage continues for any reason);
- All of your, or your spouse's life insurance coverage terminates under the group policy for any reason before **Aetna** approves your Accelerated Death Benefit request; or
- You die before **Aetna** issues the Accelerated Death Benefit payment.

Accelerated Death Benefit Payment *(GR-9N 03-085 02-VA)*

If your request is approved, **Aetna** will pay you the Accelerated Death Benefit in a lump sum. The amount will be reduced by interest charges that would have accrued on the requested amount.

- The interest charge is equal to the sum of daily interest that would have accrued on that amount during the Accelerated Death Benefit months that follow your request for an Accelerated Death Benefit payment.

Important Reminder

The interest rate used to calculate the interest charge will not exceed the current yield on 90-day Treasury bills on the date the Accelerated Death Benefit payment is requested.

Effect of an Accelerated Death Benefit Payment on:

Your Life Insurance Benefit

The amount of life insurance covering you, your spouse will be reduced by the amount of the Accelerated Death Benefit payment, plus the interest charges.

Life Conversion

An Accelerated Death Benefit payment affects the amount of life insurance you, your spouse is eligible to convert to an individual policy. The converted amount will be limited to the reduced amount of life insurance after the Accelerated Death Benefit payment.

Refer to the *Converting to an Individual Life Insurance Policy* section for more information about the conversion privilege.

Extended Benefits Under the Permanent and Total Disability Feature

You may apply for an Accelerated Death Benefit payment if you have qualified for an extension of your life insurance because of your permanent and total disability, as long as you have not previously requested and received an Accelerated Death Benefit payment. All of the terms of the Accelerated Death Benefit feature will apply to an Accelerated Death Benefit request you make while your life insurance is being extended under the terms of the permanent and total disability provision.

For more information about the permanent and total disability provision, refer to the *Permanent and Total Disability* section.

Reductions in ADB Benefits Due to Age or Retirement

The plan's age and retirement reduction rules will be applied to an ADB payment. If your life insurance amount or the life insurance of your spouse would be reduced due to age or retirement in the ADB months following the date you request an ADB, the ADB payment will be adjusted accordingly. The ADB payment will be calculated by multiplying:

- The percentage of the life insurance amount that you requested; times
- The amount of life insurance that would remain in effect after any reduction due to age or retirement.

Please refer to *When Life Insurance Amounts Are Reduced* for information about the plan's age and retirement reduction rules.

Claims of Creditors *(GR-9N 03-090 01)*

To the extent allowed by law:

- Your Accelerated Death Benefit payment is exempt from any legal or equitable process for your debts; and
- You are not required to request an Accelerated Death Benefit in order to satisfy claims of creditors.

Tax Consequences

You may wish to carefully consider the tax consequences of requesting an Accelerated Death Benefit. Consult your counsel or tax advisor before proceeding with the request.

Important Reminder

While **Aetna** cannot offer you or your employer legal or tax advice, you should consult with your tax advisor before you request an Accelerated Death Benefit since the amount of the Accelerated Death Benefit you receive may be subject to income taxes upon receipt of the Accelerated Death Benefit payment.

Dependent Life Insurance *(GR-9N 03-010 01)*

Dependent life insurance pays a benefit to you if one of your covered dependents dies at any time or place. Aetna will pay the benefit per the *Payment of Benefits* section. If you are not living at the time the benefit is paid, the payment will be made to your executors or administrators. **Aetna** has the option to make this payment to your spouse.

The following dependents are ***not*** eligible for dependent life insurance:

- Full-time, active military personnel; and
- Children less than 14 days of age.

Refer to *Eligibility* for more information about dependent eligibility.

Employee and Dependent Life Suicide Exclusion *(GR-9N 03-095 01 VA)*

The plan will not pay a Supplemental Life Insurance benefit if:

- you, or your dependent, die by suicide, while sane or insane, or from an intentionally self-inflicted injury, within two years from the effective date of your, or your dependent's coverage. The plan will return the amount of the premium paid for the policy.

If your, or your dependent's, death occurs after two years of the effective date of your, or your dependent's, coverage, but within two years of the date that any increase in coverage becomes effective, no death benefit will be payable for any such increased amount. The plan will return the amount of the premium paid for the increased amount of the policy.

Life Insurance Portability *(GR-9N 31-045 01)*

Life Insurance coverage for which you pay the total cost, may be continued if coverage under the group plan ends because;

- you stop employment;
- you are no longer in a class that is eligible for coverage; or
- your dependents lost coverage when they no longer qualify as a covered dependent.

Eligibility Criteria

You or your dependent may elect to continue life insurance coverage under this provision if:

- The amount of your life insurance is at least $5,000;
- The amount of your spouse's life insurance is at least $1,000;
- The amount of your dependent child's Life Insurance, is at least $1,000;

You may elect to continue your dependent life insurance coverage under this provision only if you elect to continue your own life insurance coverage.

You may not elect to continue any life insurance coverage under this provision if:

- you are older than age 98;
- your dependent spouse is older than age 98;
- your dependent child is less than 12 months to reach the age where he or she will not meet the plan's definition of a dependent child;
- you are ill or injured and away from work on the date your coverage stops under this plan;
- coverage under the group policy is canceled and replaced by like coverage under another policy;
- coverage under the group policy is canceled because your employer has gone out of business; and
- coverage has been converted to an individual life policy in accordance with the plan's conversion privilege.

The Life Insurance Conversion provision does not apply to any amount of your life insurance for which you elect coverage under this provision. It may be available for:

- any amount of your life insurance to which the terms of this provision do not apply;
- any amount of your life insurance to which the terms of this provision apply, but for which you do not elect coverage under this provision; or
- any amount of your life insurance in force under this provision that stops because of age.

Electing Coverage

You must submit a written request within 31 days after your life insurance coverage under the group plan ends.

To do so you must:

- Obtain a portability request form from your employer and complete it.
- Submit the first premiums due with the completed request form to **Aetna**.

Portability Effective Date

Life insurance coverage continued under this provision will become effective following the end of the 31 day election period if you have completed a portability request form and submitted the first premium.

Your effective date of coverage under the portability feature is called your portability date.

Features of the Portable Life Insurance

All of the terms and conditions of the group life insurance will apply under the portability provision, except where noted.

Maximum Amount	You	Dependent Spouse	Dependent Children
The maximum amount, will be the lesser of the amount of insurance when coverage ends and	$500,000	$100,000	$5,000

At time of application, you can elect a smaller amount of life insurance for yourself, as long as the amount is:

- Available under the group plan for your employment classification;
- More than the amount for your spouse or dependent child; and
- Permitted by any applicable law.

Age Reductions

The amount of your or your spouse's life insurance in force reduces over time due to age. It will never decrease below $5,000. The following Age Reduction Chart illustrates the reduction(s).

Effective Date	Reduction Amount
January first following age 65	35% of original amount or $5,000
January first following age 70	60% of original amount or $5,000
January first following age 75	75% of original amount or $5,000

When you continue your life insurance coverage under this provision and your or your spouse's age is 65 years or older, the life insurance benefit amount will be limited to the reduction amount shown in the above Chart.

The conversion privilege does not apply to any amount of life insurance for which you elect coverage under this provision. However, the conversion privilege may be available for:

- Any amount of life insurance to which the terms of this portability provision do not apply;
- Any amount of life insurance to which the terms of this portability provision apply, but for which you do not elect coverage under this provision;
- Any amount of life insurance in force under this provision that ceases because of age.

Permanent and Total Disability Feature

The plan's permanent and total disability feature is available to you only. It is not available to any of your covered dependents. It applies only to disabilities that begin after you have paid your first premium for this coverage. However:

- The permanent and total disability feature is the same as the life plan's permanent and total disability feature. All terms and conditions set forth under the permanent and total disability feature under the life insurance plan continue to apply. Please refer to *Permanent and Total Disability* in the life plan section of this Booklet-Certificate.

You are permanently and totally disabled only if disease or injury stops you from working at any reasonable job, as defined in the *Permanent and Total Disability* Feature.

- Any insurance extended under this feature will cease on the first anniversary of your portability effective date following the date you reach age 65.

Accelerated Death Benefit

The accelerated death benefit provision, if included in the life plan, does not apply to life insurance in force under this portability provision.

Premium and Billing Charges

Your premiums for fully contributory coverage under this provision will change on your portability date, and on each subsequent January 1.

Premiums for coverage under this provision will be paid directly to **Aetna**.

The premium rate will include a fee for the direct billing services **Aetna** provides. The fee for direct billing may change, but not more than once a year.

Termination of Coverage

Your life insurance coverage under this provision will end on the first to occur of:

- 31 days following the date the required premium contribution for the coverage is due and not paid.
- The date of your death.
- The first anniversary of your Portability Effective Date following the date you reach age 99.

Life insurance coverage for your dependents will end:

- For your spouse, the first anniversary of his or her portability date following the date your spouse reaches age 99.
- For your dependent child, the first anniversary of his or her portability date following the date he or she reaches his or her eligibility age for portability coverage.
- The date either the spouse or child no longer qualifies as a defined dependent.
- The date of your death.

Changes to Your Coverage Amounts *(GR-9N-03-015-03)*

The amount of your life insurance benefit depends on a variety of factors, including your earnings, employment status, and employee class. Your benefit level may change as the result of a change in one or more of these factors.

Changes in Contributory Coverage

A change in your rate of earnings, employment status or employee class may change the amount of your life insurance coverage. A reduction in your coverage will be effective on:

- The date you request a change in your life insurance coverage; or
- The date your earnings, status or class changes for all other coverage.

An increase in your insurance coverage will be effective on the date your earnings, status or classification changes. If you are not actively at work on the date of the change, the increase in any coverage will be postponed until you return to active work for one full day.

You have the right to refuse an increase in life insurance coverage. You must make this request within 31 days of the date the change would have become effective.

Important Reminder
If you refuse an increase in life insurance, future changes in your earnings, status or class will not increase your coverage, unless **Aetna** gives written consent.

A retroactive change in your rate of earnings, status or classification will not change your coverage retroactively. Any resulting change in coverage will be effective on the date **Aetna** receives notice of the change, or as otherwise agreed upon between **Aetna** and your employer.

The rules described above do not apply to reductions due to age or retirement. For more information, please refer to *When Life Insurance Amounts Are Reduced* sections.

Changes in Benefit Level

If a change in benefit level increases or decreases your insurance coverage, your new coverage amounts will be effective on the date of the change. If you are not actively at work on the date of the change, the increase in any coverage will be postponed until you return to active work for one full day.

You have the right to refuse an increase in life insurance coverage. You must make this request within 31 days of the date the change would have become effective.

Important Reminder
If you later decide to elect the increase (or any future increase) in life insurance, the change will be effective on the date **Aetna** gives written consent.

Changing Your Elections

You must provide **Aetna** with evidence of good health if:

- You did not enroll for supplemental life insurance when you first became eligible, and now want to enroll; or
- You would like to increase the amount of your supplemental life insurance, except as described in the Evidence Requirements section of your *Schedule of Benefits*.

Your enrollment or increase in supplemental life insurance will be effective on the date **Aetna** approves your evidence of good health.

Important Reminder
Aetna may require you to undergo a health exam at your own expense to verify your good health.

Changes in Non-Contributory Coverage *GR-9N-03-020-03)*

An increase or decrease in the amount of your coverage as the result of a change in your rate of earnings, employment status, employee class, or benefit level will become effective on the date the change occurs as long as you are actively at work. If you are not actively at work on the date of the change, any increase will be postponed until you return to active work for one full day.

A retroactive change in your rate of earnings, status or classification will not change your coverage retroactively. Any resulting change in coverage will be effective on the date **Aetna** receives notice of the change, or as otherwise agreed upon between **Aetna** and your employer.

These rules do not apply to reductions in your coverage due to age or retirement. For more information, please refer to *When Life Insurance Amounts Are Reduced* section.

Changes in Dependent's Coverage *(GR-9N 03-020 03)*

An increase or decrease in the amount of coverage for your dependent, as the result of a change in the dependent's age, status or benefit level, will become effective on the date the age, status or benefit level change occurs. If you are not actively at work on the date of the change, the increase in your dependent's coverage will be postponed until you return to active work for one full day.

When Life Insurance Coverage Amounts are Reduced *(GR-9N 03-020 01)*

Age Reduction Rules

Life insurance amounts will be reduced at age 70, then continue to reduce according to the schedule below.

If You Are Age:	Your Insurance Amounts Will Be:
70	65% of your life amount
75	45% of your life amount
80 and over	30% of your life amount

Reductions are based on the amount of life insurance coverage amounts in force on the day prior to the first day of the month in which you attain age 70.

The reduction will take effect on the date in which you attain the limiting age.

If you become eligible for coverage after you reach age 70, your amount of life insurance will be figured by multiplying:

- The amount of insurance you would have been eligible for prior to age 70; times
- The applicable percentage, based on your current age, as shown in the above schedule.

When You Retire *(GR-9N 03-020 01)*

Life Insurance coverage ends when you retire.

When Coverage Ends *(GR-9N-30-005-05 VA)*

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

When Coverage Ends For Employees *(GR-9N-30-005-05 VA)*

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer; or
- Your employment stops for any reason, including job elimination or being placed on severance. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, Aetna may deem your employment to continue, for purposes of remaining eligible for coverage under this Plan, as described below:
  - If you are not **actively at work** due to **illness or injury**, your coverage may continue until stopped by your employer, but not beyond 12 months from the start of the absence.
  - If you are not **actively at work** due to temporary lay-off or leave of absence, your coverage may continue until stopped by your employer. Your coverage will not continue beyond the end of the policy month after the policy month in which your absence started. A "policy month" is defined in the group policy on file with your employer.
  - If you are eligible as a permanently and totally disabled employee, your coverage may be deemed to continue for Life Insurance while you remain eligible.

It is your employer's responsibility to let **Aetna** know when your employment ends. The limits above may be extended only if **Aetna** and your employer agree, in writing, to extend them.

When Coverage Ends for Dependents *(GR-9N-30-015-02)*

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make the required contribution toward the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends* for Employees;
- Your dependent is no longer eligible for coverage. In this case, coverage ends at the end of the calendar month when your dependent no longer meets the plan's definition of a dependent. However, when a dependent child is a full-time student who is on a medically necessary leave of absence from school, coverage under this plan will remain in force for up to 12 months from the date the dependent ceases to be a full-time student, or until the dependent no longer meets the plan's definition of a dependent, whichever occurs first; or
- As permitted under applicable federal and state law, your dependent becomes eligible for comparable benefits under this or any other group plan offered by your employer as an employee.
- Your life insurance is being extended under this plan as a permanently and totally disabled employee.

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after your dependent reaches any limiting age. See *Continuation of Coverage* for more information.

Continuation of Coverage *(GR-9N-31-010-03 VA)*

Handicapped Dependent Children *(GR-9N-31-015-02 VA)*

Life Insurance for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However:

- Life Insurance may not be continued if the child has been issued an individual life conversion policy.
- Life Insurance may not be continued if at the time you become eligible for dependent coverage under this plan and your child's age has exceeded the maximum age for dependent children under this plan, even if your child was covered under a prior group plan on the day before this plan takes effect.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to **Aetna** no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

Aetna will have the right to require proof of the continuation of the handicap. **Aetna** also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

Converting to an Individual Life Insurance Policy *(GR-9N 31-030 01)*

Eligibility

You may be eligible to apply for an individual life insurance policy, called a conversion policy, if the group plan coverage for you or your dependents ends because:

- Your employment was terminated;
- You are no longer in an eligible class; or
- Your coverage amount has been reduced because of the group policy age, pension or retirement reductions.

You may also convert your covered dependents life insurance to an individual policy, if:

- You are no longer in an eligible class that is eligible for dependent coverage; or
- Your dependent no longer qualifies as a covered dependent due to age.

Your dependents may convert their coverage as an individual policy if their coverage ends because:

- Your marriage ends in divorce or annulment; or
- You die.

In these circumstances, an application for conversion can be completed and submitted to **Aetna** without providing proof of good health.

When life insurance ends because that part of the group contract ends or because that part of the group contract discontinues as to your employee class, and your life insurance has been in force under the group contract for at least 5 years in a row, the amount in force less the amount of any group life insurance for which the person becomes eligible within 31 days of the date coverage ended may be converted to an individual policy. The maximum amount that can be converted by each person is $10,000.

Features of the Conversion Policy

The amount of coverage in the conversion policy will be determined at the time of application. The policy will take into consideration:

- Your age or the age of your dependents,
- The group plan's policy value in force in the prior 5 year period and the current entitlement under the group plan,
- Aetna's available products at the time of application.

The converted policy may be any kind of individual policy then customarily being issued for the amount being converted and for your age (nearest birthday) on the date it will be issued. The provisions of the conversion policy may not be the same as the provisions of the group plan. The conversion policy may not be a term policy, may not include disability or other supplementary benefits, it may contain exclusions, or may have exclusions that are different from those in the group policy. Once your individual policy becomes effective it will replace the benefits and privileges of your former group plan.

Your Premiums and Payments

Aetna will set the premium cost for the converted policy at the customary rates in effect at the time the policy is issued. You will be responsible for making premium payments on a timely basis.

Electing Conversion

You or your dependents will need to apply for an individual policy within 31 days after your group life insurance coverage ends or is reduced.

Your employer will provide you or your dependents with a copy of the application for conversion of term life insurance, which features detailed instructions.

Submit your completed application along with the first premium payment to Aetna within 31 days after your insurance ends for the reasons stated above.

When An Individual Policy Becomes Effective

Your individual policy will become effective after Aetna has processed your completed application and premium payment. The individual policy will become effective at the end of the 31 day period described in the *Electing Conversion* section.

Impact of Death during Conversion Application Timeframe

If you or your dependent die during the 31-day conversion period and before the individual policy becomes effective, benefits to your beneficiary will be paid through your group plan. The amount payable is limited to the maximum amount that would have been converted to your individual policy. This limit will apply even if Aetna has not received a conversion application or the first premium payment for the individual policy.

If You Are Totally Disabled

You may be entitled to certain rights or benefits under the life insurance portion of this plan if you are or become permanently and totally disabled.

If you exercise your conversion privilege, and it is later determined that you are eligible for life insurance under this plan because you were permanently and totally disabled at the time your Life Insurance ended, please follow the guideline in the description of the disability provision in the *Life Insurance Plan* section.

General Provisions *(GR-9N-32-005-02 VA)*

Confidentiality

Information contained in your medical records and information received from any provider incident to the provider patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **Aetna** when necessary for the operation of the plan and administration of this Booklet-Certificate, or other activities, as permitted by applicable law. You can obtain a copy of **Aetna's** Notice of Information Practices at www.aetna.com.

Additional Provisions

The following additional provisions apply to your coverage:

- You cannot receive multiple coverage under the plan because you are connected with more than one employer.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the plan. Additional provisions are described elsewhere in the *group policy*. If you have any questions about the terms of the plan or about the proper payment of benefits, contact your employer or **Aetna**.
- Your employer hopes to continue the plan indefinitely but, as with all group plans, the plan may be changed or discontinued with respect to your coverage.

Assignments

An assignment is the transfer of your rights under the group policy to a person you name. You may assign, as a gift, all ownership of your Life Insurance benefit. **Aetna** and your employer must give written consent to the assignment.

To request assignment of your Life Insurance you must complete an assignment form. Forms are available from your employer. Send the completed form to **Aetna** for consent. You may wish to contact legal counsel prior to assigning your life insurance coverage rights. Neither your employer nor **Aetna** guarantees or assumes any obligation concerning the sufficiency or validity of any assignment for purposes of your tax or estate planning.

Claims of Creditors

Life benefit payments are exempt from legal or equitable process for your debts, where permitted by law. The exemption applies to the debts of your beneficiary, too.

Misstatements *(GR-9N-32-005-02 VA)*

If any fact as to the Policyholder or you is found to have been misstated, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

All statements made by the Policyholder or you shall be deemed representations and not warranties. No written statement made by you shall be used by **Aetna** in a contest unless a copy of the statement is or has been furnished to you or your beneficiary, or the person making the claim.

Aetna's failure to implement or insist upon compliance with any provision of this policy at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

Incontestability *(GR-9N-32-005-02 VA)*

During the first two years that your insurance is in force, any statement that you have made may be used by **Aetna** in contesting the validity of that coverage. This also applies to any increase in your coverage for the two years that follow the effective date of that increase, if evidence of good health was required in order for the increase to take effect.

Once coverage (including any increases in coverage) has been continuously in effect for two years, the validity of your insurance (or increase in coverage) under this plan shall not be contested by **Aetna** unless your statement was in writing on a form signed by you and was fraudulently made in order to obtain that coverage or increase.

Aetna may also contest the validity of your insurance at any time under this plan for non-payment of premiums when due.

Reporting of Claims *(GR-9N-32-020-01)*

You are required to submit a claim to **Aetna** in writing. Claim forms may be obtained from **Aetna.**

Your claim must give proof of the nature and extent of the loss. You must furnish true and correct information as **Aetna** may reasonably request.

Reporting of Life Insurance Claims

In addition to the above, a claim must be submitted to **Aetna** in writing.

Payment of Benefits *(GR-9N-32-005-02-VA)*

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

Any death benefit payable under the Life Insurance Plan for the loss of life will be paid in accordance with the beneficiary designation. The total proceeds of any benefit will be paid by delivery of a checkbook. One check may be written by the checkbook holder to access the entire proceeds, or multiple checks may be written until the entire checkbook balance is withdrawn or the checkbook balance drops below Aetna's minimum balance requirements. **Aetna** will credit interest compounded daily on the checkbook balance not withdrawn at a guaranteed minimum rate equal to the current Bank Rate Monitor Index® which tracks money market interest rates paid on bank deposits, or an equivalent measure if this index is not available, plus 0.25%.

Payments, however, made outside the United States, to an assignee, to a representative of a beneficiary, to a non-natural person, on behalf of a minor, for accelerated death benefits, or in an amount less than $5,000 will be paid by check and not by delivery of a checkbook.

If your beneficiary is a minor or, in **Aetna's** opinion, legally unable to give a valid release for payment of any life insurance benefit or accidental death and personal loss coverage, the benefit will be payable to the guardian of the estate of the minor, or to the custodian under the Uniform Transfer to Minors Act, or an adult caretaker, when permitted under applicable state law.

Contacting Aetna *(GR-9N-32-005-01)*

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna's** Home Office at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may visit **Aetna's** web site at www.aetna.com.

Effect of Prior Coverage - Transferred Business *(GR-9N 32-040-01)*

If your coverage under any part of this plan replaces any prior coverage for you, the rules below apply to that part.

"Prior coverage" is any plan of group coverage that has been replaced by coverage under part or all of this plan; it must have been sponsored by your employer (e.g., transferred business). The replacement can be complete or in part for the eligible class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan.

Your Life Insurance coverage under this plan replaces and supersedes any prior life insurance coverage. It will be in exchange for everything as to the prior life insurance coverage. If you or your beneficiary becomes entitled to claim under the prior life insurance coverage, your Life Insurance coverage under this plan will be canceled. This will be done as of its effective date. Any premiums paid for your Life Insurance coverage under this plan will be returned to your employer.

The beneficiary you named under a prior **Aetna** life insurance coverage plan will apply to this plan. This can be changed according to the terms of this plan.

(GR-9N 32-040-01) (GR-9N-32-005-02 VA)
The Active Work Rule will not apply on the day after the date your prior coverage terminates. The amount of your life insurance coverage will be the amount in effect under the prior coverage on the day before you become insured for Life Insurance coverage under this policy.

Any Age Reduction Rule or Retirement Rule of this policy will apply to you if:

- The Rules do not provide a greater amount of Life Insurance coverage than your amount under the prior coverage; or
- Your Life Insurance coverage had not been reduced under the prior coverage due to age or retirement.

If you do not return to active work within 12 months from the date Life Insurance goes into effect, Life Insurance will cease at the end of such 12 month period. This will happen unless **Aetna** determines you are eligible for extended insurance as a permanently and totally disabled employee under the terms of any Permanent and Total Disability Benefit of this policy.

This provision shall terminate if:

- Your Life Insurance terminates; or
- You meet the Active Work Rule.

If you stay insured or again become eligible, this policy shall apply to you as though this provision were not included.

Performance Guarantees *(GR-9N-32-045-01 VA)*

Aetna may offset the Policyholder's premium due to our failure to provide the agreed upon levels of service. Such service levels are guaranteed by **Aetna** and agreed to, in writing, by **Aetna** and the Policyholder.

The offset is based upon a percentage of the projected annual premium which is due over the term of the period for which service levels are guaranteed. At the end of each guarantee period, **Aetna** will compile its performance guarantee results. If necessary, **Aetna** will offset future or prior premium by an amount equal to any penalties incurred by **Aetna.**

Glossary

(GR-9N-34-005-01 VA)

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet-Certificate.

A *(GR-9N-34-005-02)*

Accident *(GR-9N-34-005-02)*

This means a sudden external trauma that is; unexpected; and unforeseen; and is an identifiable **occurrence** or event producing, at the time, objective symptoms of a external bodily **injury**. The **accident** must occur while the person is covered under this Policy. The **occurrence** or event must be definite as to time and place. It must not be due to, or contributed by, an **illness** or disease of any kind including a reaction to a condition that manifests within the human body or a reaction to a drug or medication regardless of the reason you have consumed the drug or medication.

Active at Work; Actively at Work; Active Work *(GR-9N-34-005-02)*

You will be considered to be active at work, actively at work or performing active work on any of your employer's scheduled work days if, on that day, you are performing the regular duties of your job on a full time basis for the number of hours you are normally scheduled to work. In addition, you will be considered to be actively at work on the following days:

- any day which is not one of your employer's scheduled work days if you were actively at work on the preceding scheduled work day; or
- a normal vacation day.

Aetna

Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

H *(GR-9N-34-040-02 VA)*

Hospital

An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day R.N. service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

Hospitalization

A continuous confinement as an inpatient in a **hospital** for which a room and board charge is made.

I *(GR-9N-34-045-02 VA)*

Illness *(GR-9N-34-045-02 VA)*
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Injury (GR-9N-34-045-02 VA)
An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.

The act or event must be definite as to time and place. An **injury** is not the direct result of **illness**.

P *(GR-9N-34-080-05 VA)*

Physician
A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- A physician is not you or related to you.

S *(GR-9N-34-095-05 VA)*

Skilled Nursing Facility
An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**:
  - Professional nursing care by an R.N., or by a L.P.N. directed by a full-time R.N.; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a **physician** or an R.N.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.

- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law.
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by:
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of **Hospitals** of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation **hospitals** (all levels of care, e.g. acute) and portions of a **hospital** designated for skilled or rehabilitation services.

Skilled nursing facility does not include:

- Institutions which provide only:
  - Minimal care;
  - Custodial care services;
  - Ambulatory; or
  - Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, substance abuse or mental disorders.

T *(GR-9N 34-100-02)*

Terminal Illness

Terminal Illness means a medical prognosis of 12 months to live.

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law.

Some of the ways in which personal information is used include claim payment; utilization review and management; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Information Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call 1-866-825-6944 or visit our Internet site at www.aetna.com.

Additional Information Provided by

Computer Sciences Corporation

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

The benefits described in your booklet-certificate (Booklet) are provided under a group insurance policy (Policy) issued by the Aetna Life Insurance Company (Insurance Company) and are subject to the Policy's terms and conditions. The Policy is incorporated into, and forms a part of, the Plan. The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:
CSC Group Insurance Plans

Employer Identification Number:
95-2043126

Plan Number:
502

Type of Plan:
Employer Life Insurance

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
CSC
Corporate Employee Benefits Department
3170 Fairview Park Dr.
Falls Church, VA 22042
Telephone Number: 703-876-1000

Agent For Service of Legal Process:
CT Corporation Systems Service
Computer Sciences Corporation
3170 Fairview Park Dr.
Falls Church, VA 22042

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:
December 31

Source of Contributions;
Employer and Employee

Procedure for Amending the Plan:
The Employer may amend the Plan from time to time by a written instrument signed by the Plan Administrator.

ERISA Rights
As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, your Employer may allow you to continue coverage for which you are covered under the group contract on the day before the approved FMLA leave starts. This includes coverage for your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If any coverage your Employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If the group contract provides continuation of coverage (for example, upon termination of employment), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment *(GR-9N-Appeals 01-01 01-VA)*

Policyholder:	Computer Sciences Corporation
Group Policy No.:	GP-838912
Rider:	Virginia Complaint and Appeals Life Insurance Rider
Issue Date:	June 11, 2012
Effective Date:	January 1, 2012

Appeals -Life Coverage

The group policy specified above has been amended. The following summarizes the changes in the group policy, and the Certificate of Insurance describing the policy terms has been amended to include the following Appeals Procedure. This amendment is effective on the date shown above.

Appeals Procedure

Definitions

Adverse Benefit Determination: A denial; termination of; or failure to provide or make payment (in whole or in part) for a benefit.

Such **adverse benefit determination** may be based on your eligibility for coverage or your eligibility for benefits.

Appeal: A written request to Aetna to reconsider an **adverse benefit determination.**

Note: If applicable state law requires the Plan to take action on a claim or appeal within a shorter timeframe, the shorter period will apply.

Filing Life Claims under the Plan

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative.

An "authorized representative" means your legal spouse or adult child, or a person you authorize, in writing, to act on your behalf. In addition, the Plan will recognize a court order giving a person authority to submit claims on your behalf.

Claim Determinations – Group Life Coverage *(GR-9N-Appeals 01-04 01)*

Aetna will make notification of a claim determination as soon as possible but not later than 90 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 90 calendar day claim determination period is required. Such an extension, of not longer than 90 additional calendar days, will be allowed if Aetna notifies you within the first 90 calendar day period. Aetna must notify you, prior to the end of the first 90 calendar day period, of the special circumstances requiring the extension and the date by which a decision can be expected.

Appeals of Adverse Benefit Determinations *(GR-9N-Appeals 01-06 01)*

You may submit an **appeal** if Aetna gives notice of an **adverse benefit determination.**

You have 60 calendar days following the receipt of notice of an **adverse benefit determination** to request your **appeal.** Your **appeal** may be submitted in writing and should include:

- Your name;
- Your employer's name;
- A copy of Aetna's notice of an **adverse benefit determination;**
- Your reasons for making the **appeal;** and
- Any other information you would like to have considered.

You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records or information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

Send your **appeal** to the address shown on the notice of **adverse benefit determination.**

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf by providing written consent to Aetna.

Appeal – Group Life Claims *(GR-9N-Appeals 01-09 01)*

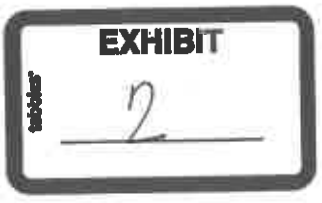
Aetna shall issue a decision within 60 calendar days of receipt of the request for an **appeal.** If Aetna determines that due to special circumstances an extension of time for claim processing is required, such an extension, of not longer than 60 additional calendar days, will be allowed if Aetna notifies you within the first 60 calendar day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which a decision can be expected.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

YOUR BENEFIT PLAN

CSRA INC.



Basic Term Life, Supplemental Dependent Life, Supplemental Term Life

State Notices

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions described in the group insurance certificate. If you live in a state that has such requirements, those requirements will apply to your coverage. State-specific requirements that may apply to your coverage are summarized below. In addition, updated state-specific requirements are published on our website. You may access the website at www.thehartford.com. If you are unable to access this website, want to receive a printed copy of these requirements, or have any questions or complaints regarding any of these requirements or any aspect of your coverage, please contact your Employee Benefits Manager; or you may contact us as follows:

The Hartford
Group Benefits Division, Customer Service
P.O. Box 2999
Hartford, CT 06104-2999
1-800-523-2233

If you have a complaint and contacts between you, us, your agent, or another representative have failed to produce a satisfactory solution to the problem, some states require we provide you with additional contact information. If your state requires such disclosure, the contact information is listed below with the other state requirements and notices.

If your policy is governed under the laws of Maryland, any of the benefits, provisions or terms that apply to the state you reside in as shown below will apply only to the extent that such state requirements are more beneficial to you.

Alaska:

1. If notice of Your **Conversion Right** is not received by You on the date Your or Your Dependent's coverage terminates, You have 15 days from the date You receive the notice.
2. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
3. The **Spouse** definition will always include domestic partners, civil unions, and any other legal union recognized by state law.

Arizona:

1. **NOTICE:** The Certificate may not provide all benefits and protections provided by law in Arizona. Please read the Certificate carefully.

Arkansas:

1. **For Your Questions and Complaints:**
   Arkansas Insurance Department
   Consumer Services Division
   1200 West Third Street
   Little Rock, AR 72201-1904
   Toll Free:1(800) 852-5494
   Local: 1(501) 371-2640

California:

1. The **Policy Interpretation** provision, if shown in the General Provisions section of the Certificate, does not apply to you. The following requirement applies to you:

   Eligibility Determination: *How will We determine Your or Your Dependent's eligibility for benefits?*
   We, and not Your Employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your or Your Dependent's eligibility for benefits for any claim You or Your beneficiaries make on The Policy. We will:
   1) obtain with Your or Your beneficiaries' cooperation and authorization if required by law, only such information that is necessary to evaluate Your or Your beneficiaries' claim and decide whether to accept or deny Your or Your beneficiaries' claim for benefits. We may obtain this information from Your or Your beneficiaries' Notice of Claim, submitted proofs of loss, statements, or other materials provided by You or others on Your behalf; or, at Our expense We may obtain necessary information, or have You or Your Dependent's physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at Your or Your beneficiaries' option and at Your or Your beneficiaries'

expense, You or Your beneficiaries may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of Your or Your beneficiaries' choice. You or Your beneficiaries should provide Us with all information that You or Your beneficiaries want Us to consider regarding Your or Your beneficiaries' claim;

2) As part of Our routine operations, We will apply the terms of The Policy for making decisions, including decisions on eligibility, receipt of benefits and claims or explaining policies, procedures and processes;
3) If We approve Your claim, We will review Our decision to approve Your or Your beneficiaries claim for benefits as often as is reasonably necessary to determine Your or Your Dependent's continued eligibility for benefits;
4) If We deny Your or Your beneficiaries' claim, We will explain in writing to You or Your beneficiaries the basis for an adverse determination in accordance with The Policy as described in the provision entitled **Claim Denial.**

In the event We deny Your or Your beneficiaries' claim for benefits, in whole or in part, You or Your beneficiaries can appeal the decision to Us. If You or Your beneficiaries choose to appeal Our decision, the process You or Your beneficiaries must follow is set forth in The Policy provision entitled **Claim Appeal.** If You or Your beneficiaries do not appeal the decision to Us, then the decision will be Our final decision.

2. **For Your Questions and Complaints:**
   State of California Insurance Department
   Consumer Communications Bureau
   300 South Spring Street, South Tower
   Los Angeles, CA 90013
   Toll Free: 1(800) 927-HELP
   TDD Number: 1(800) 482-4833

Colorado:

1. The **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.
2. The **Dependent Child(ren)** definition will always include children related to You by civil union.
3. The **Spouse** definition will always include civil unions.
4. Entering a civil union, terminating a civil union, the death of a party to a civil union or a party to a civil union losing employment, which results in a loss of group insurance, will all constitute as a **Change in Family Status.**

Florida:

1. **Legal Actions** cannot be taken against Us more than 5 years after the date Proof of Loss is required to be furnished according to the terms of The Policy.
2. **NOTICE:** The benefits of the policy providing you coverage may be governed primarily by the laws of a state other than Florida.

Georgia:

1. **NOTICE:** The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family abuse.

Idaho:

1. **For Your Questions and Complaints:**
   Idaho Department of Insurance
   Consumer Affairs
   700 W State Street, 3rd Floor
   PO Box 83720
   Boise, ID 83720-0043
   Toll Free: 1-800-721-3272
   Web Address: www.DOI.Idaho.gov

Illinois:

1. **For Your Questions and Complaints:**
   Illinois Department of Insurance
   Consumer Services Station
   Springfield, Illinois 62767
   Consumer Assistance: 1(866) 445-5364

Officer of Consumer Health Insurance: 1(877) 527-9431

2. In accordance with Illinois law, insurers are required to provide the following **NOTICE** to applicants of insurance policies issued in Illinois.

STATE OF ILLINOIS
The Religious Freedom Protection and Civil Union Act
Effective June 1, 2011

The Religious Freedom Protection and Civil Union Act ("the Act") creates a legal relationship between two persons of the same or opposite sex who form a civil union. The Act provides that the parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married," or variations thereon. Insurance policies are required to provide identical benefits and protections to both civil unions and marriages. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions.

For more information regarding the Act, refer to 750 ILCS 75/1 *et seq.* Examples of the interaction between the Act and existing law can be found in the Illinois Insurance Facts, Civil Unions and Insurance Benefits document available on the Illinois Department of Insurance's website at www.insurance.illinois.gov.

Indiana:

1. **For Your Questions and Complaints:**
   Public Information/Market Conduct
   Indiana Department of Insurance
   311 W. Washington St. Suite 300
   Indianapolis, IN 46204-2787
   1(317) 232-2395

Louisiana:

1. The age limit stated in the **Continuation for Dependent Child(ren)** with Disabilities provision is increased to 21, if less than 21.
2. The following requirement applies to you:

   Reinstatement after Military Service: *Can coverage be reinstated after return from active military service?* If Your or Your Dependents' coverage ends because You or Your Dependents enter active military service, coverage may be reinstated, provided You request such reinstatement upon Your or Your Dependents' release from active military service.

   The reinstated coverage will:
   1) be the same coverage amounts in force on the date coverage ended;
   2) not be subject to any Eligibility Waiting Period for Coverage or Evidence of Insurability; and
   3) be subject to all the terms and provisions of The Policy.

Maine:

1. **NOTICE:** The laws of the State of Maine require notification of the right to designate a third party to receive notice of cancellation, to change such a designation and, to have the Policy reinstated if the insured suffers from cognitive impairment or functional incapacity and the ground for cancellation was the insured's nonpayment of premium or other lapse or default on the part of the insured.

   Within 10 days after a request by an insured, a Third Party Notice Request Form shall be mailed or personally delivered to the insured.

Maryland:

1. **NOTICE: The group insurance Policy providing coverage under the Certificate may have been issued in a**

jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

Massachusetts:

1. The definition of **Terminal Illness or Terminally Ill** shown in the **Accelerated Benefit** cannot exceed 24 months.
2. **NOTICE: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).**

   This plan is not intended to provide comprehensive health care coverage and **does not meet Minimum Creditable Coverage standards**, even if it does include services that are not available in the insured's other health plans.

   If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

Michigan:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

Minnesota:

1. You or Your Dependents must be on a documented military leave of absence in order to qualify for the Military Leave of Absence continuation shown in the **Continuation Provisions.**
2. If there are 25 or more residents of Minnesota who are covered under The Policy and those 25 residents constitute 25% or more of the total number of people covered under The Policy, the Lay Off continuation shown in the **Continuation Provisions** shall not apply to you. The following requirement applies to you:

   Minnesota Coverage Continuation: If You are voluntarily or involuntarily terminated or Laid Off by the Employer, You may elect to continue Your Life Insurance coverage (including Dependent Life coverage) by making premium payments to the Employer for the cost of continued coverage. Continued coverage will take effect on the date Your coverage would otherwise have ended and must be elected within 60 days from:
   1) the date Your coverage would otherwise terminate; or
   2) the date You receive a written notice of Your right to continue coverage from the Employer;

   whichever is later.

   The amount of premium charged may not exceed 102% of the premium paid for other similarly situated employees who are Actively at Work. The Employer will inform You of:
   1) Your right to continue coverage;
   2) the amount of premium; and
   3) how, where and by when payment must be made.

   Upon request, the Employer will provide You Our written verification of the cost of coverage.

   Coverage will be continued until the earliest of:
   1) the date You are covered under another group policy;
   2) the date the required premium is due but not paid; or
   3) the last day of the 18th month following the date of termination or Lay Off.

   Upon the termination of continued coverage, You may:
   1) exercise Your Conversion Right; or
   2) continue coverage under a group Portability policy; and
   3) qualify for Retiree coverage.

   Minnesota law requires that if Your coverage ends because the Employer fails to notify You of Your right to continue coverage or fails to pay the premium after timely receipt, the Employer will be liable for benefit payments to the extent We would have been liable had You still been covered.
3. If the following paragraph appears in the **Accelerated Benefit** provision, it does not apply to you:

In the event:

1) You are required by law to accelerate benefits to meet the claims of creditors; or
2) If a government agency requires You to apply for benefits to qualify for a government benefit or entitlement;

You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit

4. If there are 25 or more residents of Minnesota who are covered under The Policy and those 25 residents constitute 25% or more of the total number of people covered under The Policy, You are not required to be insured under The Policy for a specified period of time in order to exercise the **Conversion Right**.

Missouri:

1. The period in which You must remain Disabled to qualify for **Waiver of Premium** cannot exceed 180.
2. If Waiver of Premium is approved and You have completed the elimination period, We will retroactively refund to You, or to Your estate if You have died, any premiums paid during the period You have been continuously Disabled.
3. The **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.

Montana:

1. The time period in which You are required to be insured under The Policy in order to exercise the **Conversion Right** cannot exceed 3 years.
2. If You are eligible to receive the **Felonious Assault Benefit**, We will not exclude for losses that result from a Felonious Assault committed by a member of Your family or a member of the household in which You live.
3. **NOTICE:** Conformity with Montana statutes: The provisions of the certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of the certificate

New Hampshire:

1. Your Spouse may be eligible to continue his or her Life Insurance coverage in the event of divorce or separation as shown in the **Spouse Continuation** below:

   Spouse Continuation: *Can coverage for my Spouse be continued in the event of divorce or separation?*
   If:
   1) You are a resident of New Hampshire;
   2) You get a divorce or legal separation from a Spouse that is covered under The Policy; and
   3) the final decree of divorce or legal separation does not expressly prohibit it;

   Your former Spouse may continue his or her coverage.

   We must receive Your Spouse's written request and the required premium to continue his or her coverage within 30 days of the final decree of divorce or legal separation.

   Solely for the purpose of continuing the coverage, Your Spouse will be considered the insured person. However, Your former Spouse's coverage will not continue beyond the earliest of:
   1) the 3-year anniversary of the final decree of divorce or legal separation;
   2) the remarriage of the former Spouse;
   3) Your death;
   4) an earlier time as provided by the final decree of divorce or legal separation; or
   5) a date the coverage would otherwise have ended under the Dependent Termination Provision.

New York:

1. If the definition of **Spouse** requires the completion of a domestic partner affidavit, the requirement applies to you: The domestic partner affidavit must be notarized and requires that You and Your domestic partner meet all of the following criteria:
   1) you are both are legally and mentally competent to consent to contract in the state in which you reside;
   2) you are not related by blood in a manner that would bar marriage under laws of the state in which you reside;
   3) you have been living together on a continuous basis prior to the date of the application;

4) neither of you have been registered as a member of another domestic partnership within the last six months; and
5) you provide proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof).

The domestic partner affidavit further requires that You and Your domestic partner provide proof of financial interdependence in the form of at least two of the following:

1) a joint bank account;
2) a joint credit card or charge card;
3) joint obligation on a loan;
4) status as an authorized signatory on the partner's bank account, credit card or charge card;
5) joint ownership of holdings or investments, residence, real estate other than residence, major items of personal property (e.g., appliances, furniture), or a motor vehicle;
6) listing of both partners as tenants on the lease of the shared residence;
7) shared rental payments of residence (need not be shared 50/50)
8) listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
9) a common household and shared household expenses (e.g., grocery bills, utility bills, telephone bills, etc. and need not be shared 50/50);
10) shared household budget for purposes of receiving government benefits;
11) status of one as representative payee for the other's government benefits;
12) joint responsibility for child care (e.g., school documents, guardianship);
13) shared child-care expenses (e.g., babysitting, day care, school bills, etc. and need not be shared 50/50);
14) execution of wills naming each other as executor and/or beneficiary;
15) designation as beneficiary under the other's life insurance policy;
16) designation as beneficiary under the other's retirement benefits account;
17) mutual grant of durable power of attorney;
18) mutual grant of authority to make health care decisions (e.g., health care power of attorney);
19) affidavit by creditor or other individual able to testify to partners' financial interdependence;
20) other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

North Carolina:

1. **NOTICE:** UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, FINANCIAL AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP LIFE INSURANCE, GROUP HEALTH OR GROUP HEALTH PLAN PREMIUMS, SHALL:
   1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP LIFE INSURANCE, GROUP HEALTH INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSON INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT; AND
   2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

IMPORTANT TERMINATION INFORMATION

YOUR INSURANCE MAY BE CANCELLED BY THE COMPANY. PLEASE READ THE TERMINATION PROVISION IN THE CERTIFICATE.

THE CERTIFICATE OF INSURANCE PROVIDES COVERAGE UNDER A GROUP MASTER POLICY. THE CERTIFICATE PROVIDES ALL OF THE BENEFITS MANDATED BY THE NORTH CAROLINA INSURANCE CODE, BUT YOU MAY NOT RECEIVE ALL OF THE PROTECTIONS PROVIDED BY A POLICY ISSUED IN NORTH CAROLINA AND GOVERNED BY ALL OF THE LAWS OF NORTH CAROLINA.

North Dakota:

1. The **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.

Ohio:

1. Any references to the **Accelerated Benefit** shall be changed to the **Accelerated Death Benefit**.

Oregon:

1. The **Spouse** definition will include Your domestic partner provided You have registered as domestic partners with a government agency or office where such registration is available. You will not be required to provide proof of such registration.
2. The **Dependent Child(ren)** definition will include children related to You by domestic partnership.
3. The following Jury Duty continuation applies for Employers with 10 or more employees:

   Jury Duty: If You are scheduled to serve or are required to serve as a juror, Your coverage may be continued until the last day of Your Jury Duty, provided You:
   1) elected to have Your coverage continued; and
   2) provided notice of the election to Your Employer in accordance with Your Employer's notification policy.

Rhode Island:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

South Carolina:

1. The dollar amount stated in the third paragraph of the **Claims to be Paid** provision is changed to $2,000, if greater than $2,000.
2. If the **Continuity from a Prior Policy for Disability Extension** provision is included in the Certificate and You qualify for continued coverage, Your Amount of Insurance will be the greater of the amount of life insurance and accidental death and dismemberment principal sum that You had under the Prior Policy or the amount shown in the Schedule of Insurance. This Amount of Insurance will be reduced by any coverage amount that is in force, paid or payable under the Prior Policy or that would have been payable under the Prior Policy had timely election been made.
3. If The Policy Terminates or Your Employer ceases to be a Participating Employer and You have been approved for the **Waiver of Premium**, Your coverage under the terms of this provision will not be affected. Your Dependent coverage will continue for a period of 12 months from the date of Policy termination and will be subject to the terms and conditions of The Policy.
4. If The Policy Terminates or Your Employer ceases to be a Participating Employer and You have been approved for the **Disability Extension**, Your and Your Dependent's coverage will be continued for a period of up to 12 months from the date The Policy terminated or Your Employer ceased to be a Participating Employer, as long as premiums are paid when due. Coverage during this period will be subject to the other terms and conditions of the **Disability Extension Ceases** provision. When this extension period is exhausted, You may be eligible to exercise the **Conversion Right** for You and Your Dependent's coverage. **Portability Benefits** will not be available

South Dakota:

1. The definition of **Physician** can include You or a person Related to You by blood or marriage in the event that the Physician is the only one in the area and is acting within the scope of their normal employment.

Texas:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
2. **IMPORTANT NOTICE** **AVISO IMPORTANTE**

   To obtain information or make a complaint: Para obtener información o para presentar una

You may call The Hartford's toll-free telephone number for information or to make a complaint at:

1-800-523-2233

You may also write to The Hartford at:

P.O. Box 2999
Hartford, CT 06104-2999

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should contact the agent or the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:
This notice is for information only and does not become a part or condition of the attached document.

queja:

Usted puede llamar al número de teléfono gratuito de The Hartford's para obtener información o para presentar una queja al:

1-800-523-2233

Usted también puede escribir a The Hartford:

P.O. Box 2999
Hartford, CT 06104-2999

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:
Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con el agente o la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA:
Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

Utah:

1. We will send **Claim Forms** within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, any other written proof which fully describes the nature and extent of the claim may be submitted.
2. If the **Sending Proof of Loss** provision provides a timeframe in which proof must be submitted before it affects Your claim, this time limitation shall not apply to You.
3. When We determine that benefits are payable, We will make **Claim Payments** within no more than 45 days after **Proof of Loss** is received.
4. Any reference to fraud within the **Incontestability** provision does not apply to You.
5. A Sickness or Injury continuation of at least 6 months must be included in the **Continuation Provisions**.

Vermont:

1. The following requirement applies:

   Purpose: This requirement is intended to provide benefits for parties to a civil union. Vermont law requires that insurance contracts and policies offered to married persons and their families be made available to parties to a civil union and their families. In order to receive benefits in accordance with this requirement, the civil union must have been established in the state of Vermont according to Vermont law.

General Definitions, Terms, Conditions and Provisions: The general definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements are hereby superseded as follows:

1) Terms that mean or refer to a marital relationship or that may be construed to mean or refer to a marital relationship: such as "marriage", "spouse", "husband", "wife", "dependent", "next of kin", "relative", "beneficiary", "survivor", "immediate family" and any other such terms include the relationship created by a civil union.
2) Terms that mean or refer to a family relationship arising from a marriage such as "family", "immediate family", "dependent", "children", "next of kin", "relative", "beneficiary", "survivor" and any other such terms include the family relationship created by a civil union.
3) Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree", "termination of marriage" and any other such terms include the inception or dissolution of a civil union.
4) "Dependent" means a spouse, a party to a civil union, and/or a child or children (natural, stepchild, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.
5) "Child or covered child" means a child (natural, step-child, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

Cautionary Disclosure: THIS NOTICE IS ISSUED TO MEET THE REQUIREMENTS OF VERMONT LAW AS EXPLAINED IN THE "PURPOSE" PARAGRAPH OF THE NOTICE. THE FEDERAL GOVERNMENT OR ANOTHER STATE GOVERNMENT MAY NOT RECOGNIZE THE BENEFITS GRANTED UNDER THIS NOTICE. YOU ARE ADVISED TO SEEK EXPERT ADVICE TO DETERMINE YOUR RIGHTS UNDER THIS CONTRACT

2. Interest on a **Claim Payment** is payable from the date of death until the date payment is made at an interest rate of 6% annually or Our corporate interest rate, whichever is greater.

Virginia:

1. **For Your Questions and Complaints:**
   Life and Health Division
   Bureau of Insurance
   P.O. Box 1157
   Richmond, VA 23209
   1(804) 371-9741 (inside Virginia)
   1(800) 552-7945 (outside Virginia)

Washington:

1. The following **Disputed Diagnosis** requirement applies to You:

   Disputed Diagnosis: *What happens if a dispute occurs over whether I am Terminally Ill or my Dependent is Terminally Ill?*
   If Your or Your Dependent's attending Physician, and a Physician appointed by Us, disagree on whether You or Your Dependent are Terminally Ill, Our Physician's opinion will not be binding upon You or Your Dependent. The two parties shall attempt to resolve the matter promptly and amicably. If the disagreement is not resolved, You or Your Dependent have the right to mediation or binding arbitration conducted by a disinterested third party who has no ongoing relationship with either You or Your Dependent or Us. Any such arbitration shall be conducted in accordance with the laws of the State of Washington. As part of the final decision, the arbitrator or mediator shall award the costs of the arbitrator to one party or the other, or may divide the costs equally or otherwise.

2. A Labor Dispute continuation of at least 6 months must be included in the **Continuations Provisions**.
3. The **Dependent Child(ren)** definition will always include children related to You by domestic partnership.
4. The definition of **Spouse** will always include domestic partners.
5. The provision titled **Suicide** does not apply to you.

Wisconsin:

1. **For Your Questions and Complaints:**

To request a Complaint Form:
Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1(800) 236-8517 (outside of Madison)
1(608) 266-0103 (In Madison)

Group Term Life Insurance

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

CERTIFICATE OF INSURANCE

Policyholder: CSRA INC.
Policy Number: GL-402894
Policy Effective Date: October 31, 2015
Policy Anniversary Date: January 1, 2017

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and the Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for the Company

Lisa Levin, *Secretary* **Michael Concannon, *President***

This certificate contains an Accelerated Benefit. Any benefits received under this benefit may be taxable. You should consult a personal tax advisor for further information.

A note on capitalization in this Certificate:
Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

TABLE OF CONTENTS

SCHEDULE OF INSURANCE

The benefits described herein are those in effect as of January 1, 2017.

Cost of Coverage:
Non-Contributory Coverage: Basic Life Insurance

Contributory Coverage: Supplemental Life Insurance
Supplemental Dependent Life Insurance

Disclosure of Fees:
We may reduce or adjust premiums, rates, fees and/or other expenses for programs under The Policy.

Disclosure of Services:
In addition to the insurance coverage, We may offer noninsurance benefits and services to Active Employees.

Eligible Class(es) For Coverage: All Full-time Active Employees of CSRA Inc. who are on the United States payroll, including those employees covered by a sales incentive plan who work for an employer that offers this benefit to its employees and who are not subject to a collective bargaining agreement unless the agreement specifically includes participation in the plan's features, and who are:

1) citizens or legal residents of the United States working in the United States, its territories and protectorates;
2) Expatriates and Third-country Nationals; and
3) citizens or legal residents of Canada, as approved by Us, living and working in Canada;

excluding:

1) temporary, leased or seasonal employees; and
2) any employee living or working in a country:
   a) subject to a sanctions program administered by the United States Treasury Office of Foreign Asset Control; or
   b) not meeting our underwriting criteria.

Expatriate means a citizen or legal resident of the United States living and working on temporary assignment outside of the United States, its territories and protectorates.

Third-country National means a person who is a citizen of a country other than the United States.

Full-time Employment: at least 30 hours weekly

Annual Enrollment Period: as determined by Your Employer on a yearly basis.

Eligibility Waiting Period for Coverage:
None

Life Insurance Benefit

Amount of Life Insurance:

Basic Amount of Life Insurance

Maximum Amount

1 times Your annual Earnings rounded to the next higher $1,000 if not already a multiple of $1,000, subject to a maximum of $1,000,000.

However, in no event will Your Basic Amount of Life Insurance be less than $10,000.

Supplemental Amount of Life Insurance

Guaranteed Issue Amount	Maximum Amount
Your annual Earnings rounded to the next higher $1,000 if not already a multiple of $1,000, times 1, 2, or 3, subject to a maximum of $2,000,000.	Your annual Earnings rounded to the next higher $1,000 if not already a multiple of $1,000, times 1, 2, 3, 4, or 5, subject to a maximum of $2,000,000.

However, in no event will Your Supplemental Amount of Life Insurance be less than $10,000.

Combined Basic and Supplemental Amount of Life Insurance

Maximum Amount
$2,000,000

If Your amount of Combined Basic and Supplemental Life Insurance exceeds the Combined Maximum Amount, the Supplemental Amount of Life Insurance will be reduced, followed by a reduction in the Basic Amount of Life Insurance, if necessary.

Dependent Life Insurance Benefit

Supplemental Amount of Dependent Life Insurance

	Maximum Amount
Spouse or Domestic Partner	Option 1 $10,000 Option 2 $25,000 Option 3 $50,000 Option 4 $75,000 Option 5 $100,000
Guaranteed Issue Amount $100,000 $100,000 $100,000	Option 6 $150,000 Option 7 $200,000 Option 8 $250,000
Dependent Children: Age 15 day(s) but under age 19 year(s)	The amount You elect in increments of $5,000, subject to a minimum of $5,000 and a maximum of $25,000.

The amount of Spouse or Domestic Partner Supplemental coverage may never exceed 100% of the Combined Basic and Supplemental Amount of Life Insurance the employee is eligible for.

Reduction in Amount of Life Insurance

We will reduce the Amount of Life Insurance for You and Your Dependents by any Amount of Life Insurance in force, paid or payable:

1) in accordance with the Conversion Right;
2) under the Portability provision; or
3) under the Prior Policy.

Reduction in Coverage Due to Age

We will reduce the Life Insurance Benefit for You by the percentage indicated in the table below. This reduction will be effective on the date You attain the ages shown below. The reduction will apply to the Amount of Life Insurance in force immediately prior to the first reduction made.

Reductions also apply if:

1) You become covered under The Policy; or
2) Your coverage increases;

on or after the date You attain age 70.

Percentage by which original amount of coverage will be reduced.	Your Age	Your % Reduction
	70	35%
	75	55%
	80	70%

The reduced amount of coverage will be rounded to the next higher multiple of $1,000, if not already a multiple of $1,000. An appropriate adjustment in premium will be made.

ELIGIBILITY AND ENROLLMENT

Eligible Persons: *Who is eligible for coverage?*
All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

Eligibility for Coverage: *When will I become eligible?*
You will become eligible for coverage on the latest of:
1) the Policy Effective Date;
2) the date You become a member of an Eligible Class; or
3) the date You complete the Eligibility Waiting Period for Coverage shown in the Schedule of Insurance, if applicable.

Eligibility for Dependent Coverage: *When will I become eligible for Dependent Coverage?*
You will become eligible for Dependent coverage on the later of:
1) the date You become eligible for employee coverage; or
2) the date You acquire Your first Dependent.

No person may be insured:
1) as a Dependent and an Active Employee; or
2) as a Dependent of more than one Active Employee;
under The Policy.

Enrollment: *How do I enroll for coverage?*
For Non-Contributory Coverage, Your Employer will automatically enroll You for coverage. However, You will be required to complete a beneficiary designation form.

To enroll for Contributory Coverage, You must enroll for Your and Your Dependent's coverage electronically. Your Plan Administrator will provide instructions.

If You do not enroll for Your coverage and/or Your Dependent's coverage within 30 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll You may enroll for Your coverage and/or Your Dependent's coverage only:
1) during an Annual Enrollment Period designated by the Policyholder; or
2) within 30 days of the date You have a Change in Family Status.

Enrollment may be subject to the Evidence of Insurability Requirements provision.

Evidence of Insurability Requirements: *When will I first be required to provide Evidence of Insurability?*
We require Evidence of Insurability for initial coverage, if You:
1) enroll more than 30 days after the date You are first eligible to enroll, including electing initial coverage after a Change in Family Status;
2) enroll for an Amount of Life Insurance greater than the Supplemental Guaranteed Issue Amount, regardless of when You enroll for coverage; or
3) were eligible for any coverage under the Prior Policy, but did not enroll and later choose to enroll for that coverage under The Policy.

If Your Evidence of Insurability is not satisfactory to Us:

1) Your Amount of Life Insurance will equal the amount for which You were eligible without providing Evidence of Insurability, provided You enrolled within 30 days of the date You were first eligible to enroll; and
2) You will not be covered under The Policy if You enrolled more than 30 days after the date You were first eligible to enroll.

Dependent Evidence of Insurability Requirements: *When will my Dependents first be required to provide Evidence of Insurability?*
We require Evidence of Insurability, satisfactory to Us, for initial coverage, if You:
1) enroll for Your Dependents' coverage more than 30 days after the date You are first eligible to enroll, including electing initial coverage after a Change in Family Status; or
2) were eligible for any coverage under the Prior Policy, but did not enroll and later choose to enroll for that coverage under The Policy.

However, no Evidence of Insurability will be required if the Amount of Life Insurance for Your Dependent Child(ren) is $25,000 or less.

If Your Dependents' Evidence of Insurability is not satisfactory to Us:
1) Your Dependents' Amount of Life Insurance will equal the amount for which Your Dependents were eligible without providing Evidence of Insurability, provided You enrolled Your Dependents within 30 days of the date You were first eligible to enroll;
2) Your Dependents will not be covered under The Policy if You enrolled Your Dependents more than 30 days after the date You were first eligible to enroll.

Evidence of Insurability: *What is Evidence of Insurability?*
Evidence of Insurability must be satisfactory to Us and may include, but will not be limited to:
1) a completed and signed application approved by Us;
2) a medical examination;
3) an attending Physician's statement; and
4) any additional information We may require.

Evidence of Insurability will be furnished at Our expense except for Evidence of Insurability due to late enrollment. We will then determine if You or Your Dependents are insurable for initial coverage or an increase in coverage as described in the Increase in Amount of Life Insurance provision.

You will be notified in writing of Our determination of any Evidence of Insurability submission.

Change in Family Status: *What constitutes a Change in Family Status?*
A Change in Family Status occurs when:
1) You get married or You execute a domestic partner affidavit;
2) You and Your spouse divorce or You terminate a domestic partnership;
3) Your child is born or You adopt or become the legal guardian of a child;
4) Your spouse or domestic partner dies;
5) Your child is no longer financially dependent on You or dies;
6) Your spouse or domestic partner is no longer employed, which results in a loss of group insurance; or
7) You have a change in classification from part-time to full-time or from full-time to part-time.

PERIOD OF COVERAGE

Effective Date: *When does my coverage start?*
Non-Contributory Coverage will start on the date You become eligible.

Contributory Coverage, for which Evidence of Insurability is not required, will start on the latest to occur of:
1) the date You become eligible, if You enroll on or before that date;
2) the January 1st on or next following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
3) the date You enroll, if You do so within 30 days from the date You are eligible.

Any coverage for which Evidence of Insurability is required, will become effective on the later of:

1) the date You become eligible; or
2) the date We approve Your Evidence of Insurability.

All Effective Dates of coverage are subject to the Deferred Effective Date provision.

Deferred Effective Date: *When will my effective date for coverage or a change in my coverage be deferred?*
If, on the date You are to become covered:
1) under The Policy;
2) for increased benefits; or
3) for a new benefit;
You are not Actively at Work due to a physical or mental condition, such coverage will not start until the date You are Actively at Work.

Continuity from a Prior Policy: *Is there continuity of coverage from a Prior Policy?*
Your initial coverage under The Policy will begin, and will not be deferred if, on the day before the Policy Effective Date, You were insured under the Prior Policy, but on the Policy Effective Date, You were not Actively at Work, and would otherwise meet the Eligibility requirements of The Policy. However, Your Amount of Insurance will be the lesser of the amount of life insurance:
1) You had under the Prior Policy; or
2) shown in the Schedule of Insurance;
reduced by any coverage amount:
1) that is in force, paid or payable under the Prior Policy; or
2) that would have been so payable under the Prior Policy had timely election been made.

Such amount of insurance under this provision is subject to any reductions in The Policy and will not increase.

Coverage provided through this provision ends on the first to occur of:
1) the last day of a period of 12 consecutive months after the Policy Effective Date;
2) the date Your insurance terminates for any reason shown under the Termination provision;
3) the last day You would have been covered under the Prior Policy, had the Prior Policy not terminated; or
4) the date You are Actively at Work.
However, if the coverage provided through this provision ends because You are Actively at Work, You may be covered as an Active Employee under The Policy.

Dependent Effective Date: *When does Dependent coverage start?*
Coverage will start on the latest to occur of:
1) the date You become eligible for Dependent coverage, if You have enrolled on or before that date; or
2) the January 1st on or next following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
3) the date You enroll, if You do so within 30 days from the date You are eligible for Dependent coverage.

Coverage for which Evidence of Insurability is required, will become effective on the later of:
1) the date You become eligible for Dependent coverage; or
2) the date We approve Your Dependents' Evidence of Insurability.

In no event will Dependent coverage become effective before You become eligible.

Dependent Deferred Effective Date: *When will the effective date for Dependent coverage or a change in coverage be deferred?*
If, on the date Your Dependent, other than a newborn, is to become covered:
1) under The Policy;
2) for increased benefits; or
3) for a new benefit; and
he or she is:
1) confined in a hospital; or
2) Confined Elsewhere;
such coverage will not start until he or she:
1) is discharged from the hospital; or
2) is no longer Confined Elsewhere;

and has engaged in all the normal and customary activities of a person of like age and gender, in good health, for at least 15 consecutive days.

This Deferred Effective Date provision will not apply to Disabled children who qualify under the definition of Dependent Child(ren).

Confined Elsewhere means Your Dependent is unable to perform, unaided, the normal functions of daily living, or leave home or other place of residence without assistance.

Dependent Continuity from a Prior Policy: *Is there continuity of coverage from a Prior Policy for my Dependents?*
If on the day before the Policy Effective Date, You were covered with respect to Your Dependents under the Prior Policy, the Deferred Effective Date provision will not apply to initial coverage under The Policy for such Dependents. However, the Dependent Amount of Insurance will be the lesser of the amount of life insurance:

1) Your Dependents had under the Prior Policy; or
2) shown in the Schedule of Insurance;

reduced by any coverage amount:

1) that is in force, paid or payable under the Prior Policy; or
2) that would have been so payable under the Prior Policy had timely election been made.

Change in Coverage: *When may I change my coverage or coverage for my Dependents?*
After Your initial enrollment You may increase or decrease coverage for You or Your Dependents, or add a new Dependent to Your existing Dependent coverage:

1) during any Annual Enrollment Period designated by the Policyholder; or
2) within 30 days of the date of a Change in Family Status.

Effective Date for Changes in Coverage: *When will changes in coverage become effective?*
Any decrease in coverage will take effect on the date of the change.

Any increase in coverage will take effect on the latest of:

1) the date of the change;
2) the date requirements of the Deferred Effective Date provision are met;
3) the date Evidence of Insurability is approved, if required; or
4) the January 1st on or next following the last day of the Annual Enrollment Period, except for an increase as a result of a Change in Family Status.

Increase in Amount of Life Insurance: *If I request an increase in the Amount of Life Insurance for myself or my Dependents, must we provide Evidence of Insurability?*
If You or Your Dependents are:

1) already enrolled for an Amount of Supplemental Life Insurance under The Policy, then You and Your Dependents must provide Evidence of Insurability for any increase; or
2) not already enrolled for an Amount of Supplemental Life Insurance under The Policy, You and Your Dependents must provide Evidence of Insurability for any amount of Supplemental Life Insurance coverage including an initial amount.

In any event, if the Amount of Life Insurance You request is greater than the Guaranteed Issue Amount, You or Your Dependents, as applicable, must provide Evidence of Insurability.

If Your Evidence of Insurability is not satisfactory to Us, the Amount of Life Insurance You had in effect on the date immediately prior to the date You requested the increase will not change.

If Your Dependents' Evidence of Insurability is not satisfactory to Us, the Amount of Life Insurance he or she had in effect on the date immediately prior to the date You requested the increase will not change.

Termination: *When will my coverage end?*
Your coverage will end on the earliest of the following:

1) the date The Policy terminates;
2) the date You are no longer in a class eligible for coverage, or The Policy no longer insures Your class;
3) the date the premium payment is due but not paid;
4) the date Your Employer terminates Your employment; or
5) the date You are no longer Actively at Work;

unless continued in accordance with any one of the Continuation Provisions.

Dependent Termination: *When does coverage for my Dependent end?*
Coverage for Your Dependent will end on the earliest to occur of:
1) the date Your coverage ends;
2) the date the required premium is due but not paid;
3) the date You are no longer eligible for Dependent coverage;
4) the date We or the Employer terminate Dependent coverage; or
5) the date the Dependent no longer meets the definition of Dependent;

unless continued in accordance with the Continuation Provisions.

Continuation Provisions: *Can my coverage and coverage for my Dependents be continued beyond the date it would otherwise terminate?*
Coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way.

The amount of continued coverage applicable to You or Your Dependents will be the amount of coverage in effect on the date immediately before coverage would otherwise have ended. Continued coverage:
1) is subject to any reductions in The Policy;
2) is subject to payment of premium;
3) may be continued up to the maximum time shown in the provisions; and
4) terminates if The Policy terminates.

In no event will the amount of insurance increase while coverage is continued in accordance with the following provisions. The Continuation Provisions shown below may not be applied consecutively.

In all other respects, the terms of Your coverage and coverage for Your Dependents remain unchanged.

Leave of Absence: If You are on a documented leave of absence, other than Family and Medical Leave or Military Leave of Absence, Your coverage (including Dependent Life coverage) may be continued for 12 month(s) after the month in which the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

If You are on an approved Personal, Education, or Special Assignment leave of absence, Your coverage (including Dependent Life coverage) may be continued for up to 30 days following the month in which the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Military Leave of Absence: If You enter active full-time military service and are granted a military leave of absence in writing, Your coverage (including Dependent Life coverage) may be continued for up to 12 months. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Disability Insurance: If You are working for the Policyholder and:
1) are covered by; and
2) meet the definition of disabled under;

a group long term disability insurance policy, issued by Us to Your Employer, Your coverage (including Dependent Life coverage) may be continued for a period of 12 consecutive month(s) from the date You were last Actively at Work while You remain disabled.

Sickness or Injury: If You are not Actively at Work due to sickness or injury, all of Your coverages (including Dependent Life coverage) may be continued:
1) for a period of 12 consecutive month(s) from the date You were last Actively at Work; or
2) if such absence results in a leave of absence in accordance with state or federal family and medical leave laws, then the combined continuation period will not exceed 12 consecutive month(s).

Family and Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage(s) (including Dependent Life coverage) may be continued for up to 12 weeks, or 26 weeks if You qualify for Family Military Leave, or longer if required by other applicable law, following the date Your leave commenced. If the leave of absence ends prior to the agreed upon date, this continuation will cease immediately.

Continuation for Dependent Child(ren) with Disabilities: *Will coverage for Dependent Child(ren) with disabilities be continued?*
If Your Dependent Child(ren) reach the age at which they would otherwise cease to be a Dependent as defined, and they are:

1) age 19 or older; and
2) Disabled; and
3) primarily dependent upon You for financial support;

then Dependent Child(ren) coverage will not terminate solely due to age. However:

1) You must submit proof satisfactory to Us of such Dependent Child(ren)'s Disability within 31 days of the date he or she reaches such age; and
2) such Dependent Child(ren) must have become Disabled before attaining age 19.

Disabled means Your Dependent Child(ren) is incapable of self-sustaining employment by reason of mental retardation or physical handicap.

Coverage under The Policy will continue as long as:

1) You remain insured;
2) the child continues to meet the required conditions; and
3) any required premium is paid when due.

However, no increase in the Amount of Life Insurance for such Dependent Child(ren) will be available.

We have the right to require proof, satisfactory to Us, as often as necessary during the first two years of continuation, that the child continues to meet these conditions. We will not require proof more often than once a year after that.

Waiver of Premium: *Does coverage continue if I am Disabled?*
Waiver of Premium is a provision which allows You to continue Your coverage without paying premium, while You are Disabled and qualify for Waiver of Premium.

If You qualify for Waiver of Premium, the amount of continued coverage:

1) will be the amount in force on the date You cease to be an Active Employee;
2) will be subject to any reductions provided by The Policy; and
3) will not increase.

Eligible Coverages: *What coverages are eligible under this provision?*
This provision applies only to:

1) Your Basic Life Insurance; and
2) Your Supplemental Life Insurance.

This provision does not apply to:

You are not eligible to apply for both the Portability Benefit and Waiver of Premium for the same coverage amount for You.

Disabled: *What does Disabled mean?*
Disabled means You are prevented by injury or sickness from doing any work for which You are, or could become, qualified by:

1) education;
2) training; or
3) experience.

In addition, You will be considered Disabled if You have been diagnosed with a life expectancy of 12 months or less.

Conditions for Qualification: *What conditions must I satisfy before I qualify for this provision?*
To qualify for Waiver of Premium You must:

1) be covered under The Policy and be under age 60 when you become Disabled;
2) be Disabled and provide Proof of Loss that You have been Disabled for 9 consecutive months, starting on the date You were last Actively at Work or provide proof that You have been diagnosed with a life expectancy of 12 months or less; and
3) provide such proof within one year of Your last day of work as an Active Employee.

In any event, You must have been Actively at Work under The Policy to qualify for Waiver of Premium.

When Premiums are Waived: *When will premiums be waived?*
If We approve Waiver of Premium, We will notify You of the date We will begin to waive premium. In any case, We will not waive premiums for the first 9 month(s) You are Disabled. We have the right to:

1) require Proof of Loss that You are Disabled; and
2) have You examined at reasonable intervals during the first 2 years after receiving initial Proof of Loss, but not more than once a year after that.

If You fail to submit any required Proof of Loss or refuse to be examined as required by Us, then Waiver of Premium ceases.

However, if We deny Waiver of Premium, You may be eligible to:

1) continue coverage under the Portability Benefit; or
2) convert coverage in accordance with the Conversion Right.

If You cease to be Disabled and return to work for a total of 5 days or less during the first 9 month(s) that You are Disabled, the 9 month waiting period will not be interrupted. Except for the 5 days or less that You worked, You must be Disabled by the same condition for the total 9 month period. If You return to work for more than 5 days, You must satisfy a new waiting period.

Benefit Payable before Approval of Waiver of Premium: *What if I die before I qualify for Waiver of Premium?*
If You die within one year of Your last day of work as an Active Employee, but before You qualify for Waiver of Premium, We will pay the Amount of Life Insurance which is in force for You provided:

1) You were continuously Disabled;
2) the Disability lasted or would have lasted 9 months or more; and
3) premiums had been paid for coverage.

Waiver Ceases: *When will Waiver of Premium cease?*
We will waive premium payments and continue Your coverage, while You remain Disabled, until the date You attain Normal Retirement Age if Disabled prior to age 60.

What happens when Waiver of Premium ceases?
When the Waiver of Premium ceases:

1) If You return to work in an Eligible Class, as an Active Employee, then You may again be eligible for coverage as long as premiums are paid when due; or
2) if You do not return to work in an Eligible Class, coverage will end and You may be eligible to exercise the Conversion Right if You do so within the time limits described in such provision. The Amount of Life Insurance that may be converted will be subject to the terms and conditions of the Conversion Right. Portability will not be available.

Effect of Policy Termination: *What happens to the Waiver of Premium if The Policy terminates?*
If The Policy terminates before You qualify for Waiver of Premium:

1) You may be eligible to exercise the Conversion Right, provided You do so within the time limits described in such provision; and
2) You may still be approved for Waiver of Premium if You qualify.

If The Policy terminates after You qualify for Waiver of Premium:

1) Your Dependent coverage will terminate; and
2) Your coverage under the terms of this provision will not be affected.

Exercise of Conversion Right: *What happens to the Waiver of Premium provision if I convert my coverage?*
If You exercise Your right under the Conversion Right, this Waiver of Premium provision will automatically terminate. However, You may still be eligible for this Waiver of Premium provision if, within 12 months of conversion of Your coverage to an individual policy:

1) You fulfill all the conditions of the Waiver of Premium provision; and
2) You surrender the individual policy and all benefits and payments under the individual policy except for any refund of premiums.

Extension of the Waiver of Premium Provision: *Can the Waiver of Premium provision be Extended?*
If Your insurance is in force as a result of this Waiver of Premium provision, it will continue in force if:

1) You are no longer eligible for coverage, unless You reach Normal Retirement Age; or

2) The Policy terminates for any reason.

BENEFITS

Life Insurance Benefit: *When is the Life Insurance Benefit payable?*
If You or Your Dependents die while covered under The Policy, We will pay the deceased person's Life Insurance Benefit after We receive Proof of Loss, in accordance with the Proof of Loss provision.

The Life Insurance Benefit will be paid according to the General Provisions of The Policy.

Suicide: *What benefit is payable if death is a result of suicide?*
If You or Your Dependent commit suicide while sane or insane, We will not pay any Supplemental Amount of Life Insurance or Supplemental Amount of Dependent Life Insurance for the deceased person which was elected within the 2 year period immediately prior to the date of death. This applies to initial coverage and elected increases in coverage. It does not apply to benefit increases that resulted solely due to an increase in Earnings.

This 2 year period includes the time group life insurance coverage was in force under the Prior Policy.

Any premium paid by You during this 2 year period for initial amounts of Supplemental Life Insurance or elected increases in Supplemental Life Insurance, will be returned to Your beneficiary.

Accelerated Benefit: *What is the benefit?*
In the event that You or Your Dependent are diagnosed as Terminally Ill while the Terminally Ill person is:
1) covered under The Policy for an Amount of Life Insurance of at least $10,000; and
2) under age 60;
We will pay the Accelerated Benefit in a lump sum amount as shown below, provided We receive proof of such Terminal Illness.

The Accelerated Benefit will not be available to You unless You have been Actively at Work under The Policy.

You must request in writing that a portion of the Terminally Ill person's Amount of Life Insurance be paid as an Accelerated Benefit.

The Amount of Life Insurance payable upon the Terminally Ill person's death will be reduced by any Accelerated Benefit Amount paid under this benefit. In addition, Your remaining Amount of Life Insurance will be subject to any reductions in The Policy and will not increase once an Accelerated Benefit has been paid. Any premium required will be based on the amount of Your life insurance remaining after the Accelerated Benefit is paid under this benefit.

You may request a minimum Accelerated Benefit amount of $5,000, and a maximum of $500,000. However, in no event will the Accelerated Benefit Amount exceed 80% of the Terminally Ill person's Amount of Life Insurance. This option may be exercised only once for You and only once for each of Your Dependents.

For example, if You are covered for a Life Insurance Benefit Amount under The Policy of $100,000 and are Terminally Ill, You can request any portion of the Amount of Life Insurance Benefits from $5,000 to $80,000 to be paid now instead of to Your beneficiary upon death. However, if You decide to request only $5,000 now, You cannot request the additional $75,000 in the future.

A person who submits proof satisfactory to Us of his or her Terminal Illness will also meet the definition of Disabled for Waiver of Premium.

Any benefits received under this benefit may be taxable. You should consult a personal tax advisor for further information.

In the event:
1) You are required by law to accelerate benefits to meet the claims of creditors; or
2) if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement;
You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit.

If You have executed an assignment of rights and interest with respect to Your or Your Dependent's Amount of Life Insurance, in order to receive the Accelerated Benefit, We must receive a release from the assignee before any benefits are payable.

Terminal Illness or Terminally Ill means a life expectancy of 12 months or less.

Proof of Terminal Illness and Examinations: *Must proof of Terminal Illness be submitted?*
We reserve the right to require satisfactory Proof of Terminal Illness on an ongoing basis. Any diagnosis submitted must be provided by a Physician.

If You or Your Dependents do not submit proof of Terminal Illness satisfactory to Us, or if You or Your Dependents refuse to be examined by a Physician, as We may require, then We will not pay an Accelerated Benefit.

No Longer Terminally Ill: *What happens to my coverage if I am no longer Terminally Ill or my Dependent is no longer Terminally Ill?*
If You or Your Dependent are diagnosed by a Physician as no longer Terminally Ill and:
1) return to an Eligible Class, coverage will remain in force, provided premium is paid;
2) do not return to an Eligible Class, but You continue to meet the definition of Disabled, coverage will remain in force, subject to the Waiver of Premium provision; or
3) are not in an Eligible Class, but You do not continue to meet the definition of Disabled, coverage will end and You may be eligible to exercise the Conversion Right, if You do so within the time limits described in such provision.

In any event, the amount of coverage will be reduced by the Accelerated Benefit paid.

Conversion Right: *If coverage under The Policy ends, do I have a right to convert?*
If Life Insurance coverage or any portion of it under The Policy ends for any reason, except nonpayment of premium, You and Your Dependents may have the right to convert the coverage that terminated to an individual conversion policy without providing Evidence of Insurability. Conversion is not available for any Amount of Life Insurance for which You or Your Dependents were not eligible and covered under The Policy.

If Your or Your Spouse's or Domestic Partner's coverage under The Policy ends because:
1) The Policy is terminated; or,
2) coverage for an Eligible Class is terminated;

then You or Your Spouse or Domestic Partner must have been insured under The Policy for at least 5 years, in order to be eligible to convert coverage. The amount which may be converted under these circumstances is limited to the lesser of:
1) $10,000; or
2) the Life Insurance Benefit under The Policy less any Amount of Life Insurance for which You or Your Spouse or Domestic Partner may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of group life coverage.

If coverage under The Policy ends for any other reason, except nonpayment of premium, the full amount of Your or Your Spouse's or Domestic Partner's coverage which ended may be converted less any Amount of Life Insurance for which You or Your Spouse or Domestic Partner may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of group life coverage.

If coverage under The Policy ends for any reason, except nonpayment of premium, the full amount of Your Dependent Child(ren)'s coverage which ended may be converted less any Amount of Life Insurance for which Your Dependent Child(ren) may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of group life coverage.

Insurer, as used in this provision, means Us or another insurance company which has agreed to issue conversion policies according to this Conversion Right.

Conversion: *How do I convert my coverage or my Dependents' coverage?*
To convert Your coverage or coverage for Your Dependents, You must:
1) complete a Notice of Conversion Right form; and
2) have Your Employer sign the form.

The Insurer must receive this within:
1) 31 days after Life Insurance terminates; or
2) 15 days from the date Your Employer signs the form;

whichever is later. However, We will not accept requests for Conversion if they are received more than 91 days after Life Insurance terminates.

After the Insurer verifies eligibility for coverage, the Insurer will send You a Conversion Policy proposal. You must:
1) complete and return the request form in the proposal; and
2) pay the required premium for coverage;
within the time period specified in the proposal.

Any individual policy issued to You or Your Dependents under the Conversion Right:
1) will be effective as of the 32nd day after the date coverage ends; and
2) will be in lieu of coverage for this amount under The Policy.

Conversion Policy Provisions: *What are the Conversion Policy provisions?*
The Conversion Policy will:
1) be issued on any one of the Life Insurance policy forms the Insurer is issuing for this purpose at the time of conversion; and
2) base premiums on the Insurer's rates in effect for new applicants of Your class and age at the time of conversion.
The Conversion Policy will not provide:
1) the same terms and conditions of coverage as The Policy;
2) any benefit other than the Life Insurance Benefit; and
3) term insurance.

However, Conversion is not available for any Amount of Life Insurance which was, or is being, continued:
1) in accordance with the Waiver of Premium provision; or
2) under a certificate of insurance issued in accordance with the Portability provision; or
3) in accordance with the Continuation Provisions;
until such coverage ends.

Death within the Conversion Period: *What if I or my Dependents die before coverage is converted?*
We will pay the deceased person's Amount of Life Insurance You or Your Dependents would have had the right to apply for under this provision if:
1) coverage under The Policy terminates; and
2) You or Your Dependent die within 31 days of the date coverage terminates; and
3) We receive Proof of Loss.

If the Conversion Policy has already taken effect, no Life Insurance Benefit will be payable under The Policy for the amount converted.

Effect of Waiver of Premium on Conversion: *What happens to the Conversion Policy if Waiver of Premium is later approved?*
If You apply and are approved for Waiver of Premium after an individual Conversion Policy has been issued, any benefit payable at Your or Your Dependent's death under The Policy will be paid only if the individual Conversion Policy is surrendered. The Insurer will refund the premium paid for such Conversion Policy.

Portability Benefits: *What is Portability?*
Portability is a provision which allows You and Your Dependents to continue coverage under a group Portability policy when coverage would otherwise end due to certain Qualifying Events.

Qualifying Events: *What are Qualifying Events?*
Qualifying Events for You are:
1) Your employment terminates for any reason prior to Normal Retirement Age; or
2) Your membership in an Eligible Class under The Policy ends;
provided the Qualifying Event occurs prior to Normal Retirement Age.

Qualifying Events for Your Dependents are:
1) Your employment terminates, for any reason prior to Normal Retirement Age;
2) Your death;
3) Your membership in a class eligible for Dependent coverage ends; or
4) He or she no longer meets the definition of Dependent, however, a Dependent Child(ren) who reaches the limiting age under The Policy is not eligible for Portability;

provided the Qualifying Event occurs prior to Normal Retirement Age.

In order for Dependent Child(ren) coverage to be continued under this provision, You or Your Spouse or Domestic Partner must elect to continue coverage due to your own Qualifying Event.

Electing Portability: *How do I elect Portability?*
You may elect Portability for Your coverage after Your Supplemental Life Insurance coverage ends due to a Qualifying Event. You may also elect Portability for Your Dependent coverage if Your Dependent coverage ends due to a Qualifying Event. The Policy must still be in force in order for Portability to be available.

To elect Portability for You or Your Dependents, You must:
1) complete and have Your Employer sign a Portability application; and
2) submit the application to Us, with the required premium.

This must be received within:
1) 31 days after Life Insurance terminates; or
2) 15 days from the date Your Employer signs the application;

whichever is later. However, Portability requests will not be accepted if they are received more than 91 days after Life Insurance terminates.

After We verify eligibility for coverage, We will issue a certificate of insurance under a Portability policy. The Portability coverage will be:
1) issued without Evidence of Insurability;
2) issued on one of the forms then being issued by Us for Portability purposes; and
3) effective on the day following the date Your or Your Dependent's coverage ends.

The terms and conditions of coverage under the Portability policy will not be the same terms and conditions that are applicable to coverage under The Policy.

Limitations: *What limitations apply to this benefit?*
You may elect to continue 50%, 75%, or 100% of the Amount of Life Insurance which is ending for You or Your Dependent. This amount will be rounded to the next higher multiple of $1,000, if not already a multiple of $1,000. However, the Amount of Life Insurance that may be continued will not exceed:
1) $250,000 for You;
2) $50,000 for Your Spouse or Domestic Partner; or
3) $10,000 for Your Dependent Child(ren).

If You elect to continue 50% or 75% now, You may not continue any portion of the remaining amount under this Portability provision at a later date. In no event will You or Your Dependents be able to continue an Amount of Life Insurance which is less than $5,000.

Portability is not available for any Amount of Life Insurance for which You or Your Dependents were not eligible and covered.

In addition Portability is not available if You or Your Dependents are entering active military service.

Effect of Portability on Other Provisions: *How does Portability affect other Provisions?*
Portability is not available for any Amount of Life Insurance that You have exercised under the Conversion Right or that You have been approved for under the Waiver of Premium provision. Portability is also not available to You while Your coverage is being continued under a Continuation Provision under The Policy. However, if:
1) You elect to continue only a portion of terminated coverage under this Portability Benefit; or
2) the Amount of Life Insurance exceeds the maximum Portability amount;

then the Conversion Right may be available for the remaining amount.

The Waiver of Premium provision will not be available if You elect to continue coverage under this Portability Benefit.

GENERAL PROVISIONS

Notice of Claim: *When should I notify the Company of a claim?*

You, or the person who has the right to claim benefits, must give Us, or Our representative, written notice of a claim within 30 days after the date of death.

If notice cannot be given within that time, it must be given as soon as reasonably possible after that. Such notice must include the claimant's name, address, and the Policy Number.

Claim Forms: *Are special forms required to file a claim?*
We will send forms to the claimant to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, the claimant may submit any other written proof which fully describes the nature and extent of the claim.

Proof of Loss: *What is Proof of Loss?*
Proof of Loss may include, but is not limited to, the following:

1) a completed claim form;
2) a certified copy of the death certificate (if applicable);
3) Your Enrollment form;
4) Your Beneficiary Designation (if applicable);
5) documentation of:
   a) the date Your disability began;
   b) the cause of Your disability; and
   c) the prognosis of Your disability;
6) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
7) the names and addresses of all:
   a) Physicians or other qualified medical professionals You have consulted;
   b) hospitals or other medical facilities in which You have been treated; and
   c) pharmacies which have filled Your prescriptions within the past three years;
8) Your signed authorization for Us to obtain and release medical, employment and financial information (if applicable); or
9) any additional information required by Us to adjudicate the claim.

All proof submitted must be satisfactory to Us.

Sending Proof of Loss: *When must Proof of Loss be given?*
Written Proof of Loss should be sent to Us or Our representative within 365 day(s) after the loss. However, all claims should be submitted to Us within 90 days of the date coverage ends.

If proof is not given by the time it is due, it will not affect the claim if:

1) it was not reasonably possible to give proof within the required time; and
2) proof is given as soon as reasonably possible; but
3) not later than 1 year after it is due unless You, or the person who has the right to claim benefits, are not legally competent.

Physical Examination and Autopsy: *Can We have a claimant examined or request an autopsy?*
While a claim is pending We have the right at Our expense:

1) to have the person who has a loss examined by a Physician when and as often as We reasonably require; and
2) to have an autopsy performed in case of death where it is not forbidden by law.

Claim Payment: *When are benefit payments issued?*
When We determine that benefits are payable, We will pay the benefits in accordance with the Claims to be Paid provision, but not more than 30 days after such Proof of Loss is received.

Benefits may be subject to interest payments as required by applicable law.

Claims to be Paid: *To whom will benefits for my claim be paid?*
Life Insurance Benefits will be paid in accordance with the life insurance Beneficiary Designation provided it does not contradict the Claim Payment provision.

If no beneficiary is named, or if no named beneficiary survives You, We may, at Our option, pay:

1) the executors or administrators of Your estate;
2) all to Your surviving spouse;

3) if Your spouse does not survive You, in equal shares to Your surviving children; or
4) if no child survives You, in equal shares to Your surviving parents.

In addition, We may, at Our option, pay a portion of Your Life Insurance Benefit up to $500 to any person equitably entitled to payment by reason of having incurred expenses on Your behalf or because of expenses from Your burial. Payment to any person, as shown above, will release Us from liability for the amount paid.

If any beneficiary is a minor, We may pay his or her share, until a legal guardian of the minor's estate is appointed, to a person who at Our option and in Our opinion is providing financial support and maintenance for the minor. We will pay:
1) $200 at Your death; and
2) monthly installments of not more than $200.

Payment to any person as shown above will release Us from all further liability for the amount paid.

We will pay the Life Insurance Benefit at Your Dependent's death to You, if living. Otherwise, it will be paid, at Our option, to Your surviving spouse or the executor or administrator of Your estate.

If benefits are payable and meet Our guidelines, then You, or your Beneficiary, may elect to receive benefits in a lump sum payment or may elect to receive benefits through a draft book account. The draft book account will be owned by:
1) You, if living; or
2) Your beneficiary, in the event of Your death.

However, an account will not be established for:
1) a benefit payable to Your estate; or
2) an amount that is less than $10,000.

We will make any payments, other than for loss of life, to You. We may make any such payments owed at Your death to Your estate.

Beneficiary Designation: *How do I designate or change my beneficiary?*
You may designate or change a beneficiary by doing so in writing on a form satisfactory to Us. Only satisfactory forms sent to the Plan Administrator prior to Your death will be accepted.

Beneficiary designations will become effective as of the date You signed and dated the form, even if You have since died. We will not be liable for any amounts paid before receiving notice of a beneficiary change from the Plan Administrator.

In no event may a beneficiary be changed by a power of attorney.

Claim Denial: *What notification will my beneficiary or I receive if a claim is denied?*
If a claim for benefits is wholly or partly denied, You or Your beneficiary will be furnished with written notification of the decision. This written notification will:
1) give the specific reason(s) for the denial;
2) make specific reference to the provisions upon which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

Claim Appeal: *What recourse do my beneficiary or I have if a claim is denied?*
On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so, he or she:
1) must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
   b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
2) may request copies of all documents, records, and other information relevant to the claim; and
3) may submit written comments, documents, records and other information relating to the claim.

We will respond in writing with Our final decision on the claim.

Policy Interpretation: *Who interprets the terms and conditions of The Policy?*
We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Incontestability: *When can the Life Insurance Benefit of The Policy be contested?*
Except for non-payment of premiums, Your or Your Dependent's Life Insurance Benefit cannot be contested after two years from its effective date.

No statement made by You or Your Spouse or Domestic Partner relating to Your or Your Spouse's or Domestic Partner's insurability will be used to contest Your insurance for which the statement was made after Your insurance has been in force for two years. In order to be used, the statement must be in writing and signed by You and Your Spouse or Domestic Partner.

No statement made relating to Your Dependents being insurable will be used to contest their insurance for which the statement was made after their insurance has been in force for two years. In order to be used, the statement must be in writing and signed by You or Your representative.

All statements made by the Policyholder, the Employer or You or Your Spouse or Domestic Partner under The Policy will be deemed representations and not warranties. No statement made to affect this insurance will be used in any contest unless it is in writing and a copy of it is given to the person who made it, or to his or her beneficiary or representative.

Assignment: *Are there any rights of assignment?*
You have the right to absolutely assign all of Your rights and interest under The Policy including, but not limited to the following:
1) the right to make any contributions required to keep the insurance in force;
2) the right to convert; and
3) the right to name and change a beneficiary.

We will recognize any absolute assignment made by You under The Policy, provided:
1) it is duly executed; and
2) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility:
1) for the validity or effect of any assignment; or
2) to provide any assignee with notices which We may be obligated to provide to You.

You do not have the right to collaterally assign Your rights and interest under The Policy.

Legal Actions: *When can legal action be taken against Us?*
Legal action cannot be taken against Us:
1) sooner than 60 days after the date written Proof of Loss is furnished; or
2) more than 6 years after the date Proof of Loss is required to be furnished according to the terms of The Policy.

Workers' Compensation: *How does The Policy affect Workers' Compensation coverage?*
The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

Fraud: *What are the consequences of making fraudulent statements?*
Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Misstatements: *What happens if facts are misstated?*
If material facts about You or Your Dependents were not stated accurately:
1) the premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

DEFINITIONS

Active Employee means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.

Actively at Work means at work with Your Employer on a day that is one of Your Employer's scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your job:

1) in the usual way; and
2) for Your usual number of hours.

We will also consider You to be Actively At Work on any regularly scheduled vacation day or holiday, only if You were Actively At Work on the preceding scheduled work day.

Contributory Coverage means coverage for which You are required to contribute toward the cost. Contributory Coverage is shown in the Schedule of Insurance.

Dependent Child(ren) means:
Your children, stepchildren, legally adopted children, or any other children related to You by blood or marriage or domestic partnership who:

1) live with You in a regular parent-child relationship; and/or
2) You claimed as a dependent on Your last filed federal income tax return;

provided such children are primarily dependent upon You for financial support and maintenance and are:

1) at least 15 days old but not yet age 19;
2) age 19, but not yet age 25, and in full-time attendance (at least 12 course credit hours per semester) at an accredited institution of learning. If the institution establishes full-time status in any other manner, We reserve the right to determine whether the student continues to qualify as a Dependent; or
3) age 19 or older and Disabled. Such children must have become Disabled before attaining age 19. You must submit proof, satisfactory to Us, of such children's Disability.

Disabled means such child is:

1) incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
2) primarily dependent upon You for financial support and maintenance.

Dependents means Your Spouse or Domestic Partner and Your Dependent Child(ren). A dependent must be a citizen or legal resident of the United States of America, its territories and protectorates.

Domestic Partner means Your domestic partner who is not in active full-time military service; provided You:

1) have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for purposes of The Policy; or
2) have registered as domestic partners with a government agency or office where such registration is available and provide proof of such registration unless requiring proof is prohibited by law.

You will continue to be considered domestic partners provided You continue to meet the requirements described in the domestic partner affidavit or required by law.

Earnings means, for all Active Employees who are not covered by a formal sales incentive plan, Your annual base compensation, excluding overtime, shift differential, bonuses, living or other allowances, in effect on the last day You were Actively at Work.

Earnings means, for all Active Employees covered by a formal sales incentive plan, Your regular annual rate of pay, in effect on the last day of the prior payroll year immediately prior to the date You were last Actively At Work. Earnings include paid draws and any paid formal sales incentive amount that exceeds the draw amount paid in the prior payroll
Employer means the Policyholder.

Guaranteed Issue Amount means the Amount of Life Insurance for which We do not require Evidence of Insurability. The Guaranteed Issue Amount is shown in the Schedule of Insurance.

Non-Contributory Coverage means coverage for which You are not required to contribute toward the cost. Non-Contributory Coverage is shown in the Schedule of Insurance.

Normal Retirement Age means the Social Security Normal Retirement Age under the most recent amendments to the United States Social Security Act. It is determined by Your date of birth, as follows:

Year of Birth	Normal Retirement Age	Year of Birth	Normal Retirement Age
1937 or before	65	1955	66 + 2 months
1938	65 + 2 months	1956	66 + 4 months
1939	65 + 4 months	1957	66 + 6 months

1940	65 + 6 months	1958	66 + 8 months
1941	65 + 8 months	1959	66 + 10 months
1942	65 + 10 months	1960 or after	67
1943 through 1954	66		

Physician means a person who is:

1) a doctor of medicine, Osteopathy, Psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
2) licensed to practice in the jurisdiction where care is being given;
3) practicing within the scope of that license; and
4) not You or Related to You by blood or marriage.

Prior Policy means the group life insurance policy carried by the Employer on the day before the Policy Effective Date and will only include the coverage which is transferred to Us.

Related means Your Spouse or Domestic Partner or other adult living with You, or Your sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild.

Spouse means Your spouse or domestic partner who:

1) is not legally separated or divorced from You; and
2) is not in active full-time military service outside the continental United States, Hawaii, Puerto Rico or Alaska.

The Policy means the Policy which We issued to the Policyholder under the Policy Number shown on the face page.

We, Us, or Our means the insurance company named on the face page of The Policy.

You or Your means the person to whom this Certificate of Insurance is issued.

ERISA INFORMATION
THE FOLLOWING NOTICE
CONTAINS IMPORTANT INFORMATION

This employee welfare benefit plan (Plan) is subject to certain requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. This document serves to meet ERISA requirements and provides important information about the Plan.

The benefits described in your booklet-certificate (Booklet) are provided under a group insurance policy (Policy) issued by the Hartford Life and Accident Insurance Company (Insurance Company) and are subject to the Policy's terms and conditions. The Policy is incorporated into, and forms a part of, the Plan. The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

A copy of the Plan is available for your review during normal working hours in the office of the Plan Administrator.

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1. **Plan Name**

   CSRA INC. Fully-Insured Employee Welfare Benefits Plan

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2. **Plan Number**

   LIFE - 502

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3. **Employer/Plan Sponsor**

   CSRA INC.
   3170 Fairview Park Dr.
   Falls Church, VA 22042

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4. **Employer Identification Number**

   47-4310550

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5. **Type of Plan**

   Welfare Benefit Plan providing Group Basic Term Life, Supplemental Dependent Life, Supplemental Term Life.

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6. **Plan Administrator**

   CSRA INC.
   3170 Fairview Park Dr.
   Falls Church, VA 22042

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7. **Agent for Service of Legal Process**

For the Plan

CSRA INC.
3170 Fairview Park Dr.
Falls Church, VA 22042

For the Policy:

Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, CT 06155

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

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8. **Sources of Contributions (Life)** Basic and supplemental coverage are being offered under a single ERISA plan. The Employer may pay some or all of the premium for the basic coverage. Coverages described in the certificate/policy as noncontributory or as being paid by the Employer, if any, are those paid for directly by the Employer such that you may have no direct out of pocket expense for such coverage. However, employees who elect supplemental coverage will be required to contribute specified amounts to the plan. Any amounts paid by employees may be used to pay any benefit or expense under the plan.

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9. **Type of Administration** The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.

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10. The Plan and its records are kept on a Policy Year basis.

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11. **Labor Organizations**

    None

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12. **Names and Addresses of Trustees**

    None

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13. **Plan Amendment Procedure**

    The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

    The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

1. Receive Information About Your Plan and Benefits

a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.
c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

3. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

4. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

CLAIM PROCEDURES

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

Claim Procedures for Claims Requiring a Determination of Disability

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to our request. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, 4) a description of the review procedures and time limits applicable to such procedures, 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal, and 6) (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request, or (B) if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to the request.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, we will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a statement that you have the right to bring a civil action under section 502(a) of ERISA, 4) a statement that you may request, free of charge, copies of all documents, records, and other information relevant to your claim; 5) (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision on appeal, either (I) the specific rule, guideline, protocol or other similar criterion, or (II) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the decision on appeal and that a copy will be provided free of charge to you upon request, or (B) if the decision on appeal is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the decision on appeal, applying the terms of the Policy to your medical circumstances, or (II) a statement that such explanation will be provided to you free of charge upon request, and 6) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and

other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

The Plan Described in this Booklet is insured by the

Hartford Life and Accident Insurance Company
Hartford, Connecticut
Member of The Hartford Insurance Group

Spoke To Ken 9/12/16 ~~1-877-612-2211 HR~~

571-446-4070 Laura Cardwell

CSC

YOUR BENEFITS UPON TERMINATION OF EMPLOYMENT AFTER A 12-MONTH UNPAID LEAVE OF ABSENCE

2/9 Shirley CSC
Hartford Life Insurance

1888-563-1124 Josie

Date: 1/15/16
Name: Loraine Boyne
Personnel #: 679195
CSC Termination Date: 1/23/16

Nancy now
Ret.

Below you will find information relevant to all CSC benefits plans for employees who terminate from CSC after one year of medical leave. Some of these benefits may not apply to you. The notes in the right column of the chart below will give you pertinent information for each benefit upon termination of employment, and will indicate whether any action is required from you.

Please feel free to call your Leave Coordinator (Stephanie LaFever (703)318-2405) if you have any questions or need assistance with your forms. ~~Steph~~ ~~703-627-4015~~

Benefit	Enclosures/Action Required
Unpaid Benefits Premiums: If you are not up-to-date with your benefit premiums, the remaining premiums will be deducted from your vacation payout check if you have a vacation balance due to you from CSC. If you do not have a Vacation balance or enough to pay for your benefits owed, you will need to make arrangements to pay the remaining benefits owed. Failure to make the required payments will result in your account being sent to Collections. Employees with outstanding premium balances have up until 30 days from their CSC termination date to pay the premium.	**If Applicable** Benefits owed will be taken from your available funds in your final paycheck. You will be sent a final statement with the remaining benefits owed amount within 2 weeks from your termination date. You will have 15 days to contact the Benefits administrator to set up payments otherwise you will receive a letter from Collections with further instructions.
Healthcare Coverage Continuation (Medical, Dental, Vision) **Medical, Dental and Vision Plans** You may continue your current medical, dental, and visition coverage through COBRA. CONEXIS, CSC's COBRA administrator, will send you information and an enrollment package within two weeks from your date of termination. The package will provide information that explains your rights and the cost of continuing your coverage through COBRA.	Once you receive COBRA paperwork, complete and return it to CONEXIS if electing to continue coverage for yourself and any covered dependents.
Employee Basic Life Insurance Coverage: If the insurance company approves continuation of coverage (Waiver of Premium) your waiver of premium will continue while you are totally disabled until you reach the amended 1983 social security normal retirement age at which time you may convert coverage to an individual policy. 844-318-2947 Jacky 844-335-9041 Nicole 888-563-1124 Hartford	Carrier has approved your Waiver of Premium Request for Basic Life – coverage (No action is required from you for your Basic Life coverage). Ref# 469860

Life Ins Dept.

EXHIBIT
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Benefit	Enclosures/Action Required
Supplemental and Dependent Life Coverage: You may convert your Supplemental life and/or Dependent Life coverage, if applicable to an individual policy if you wish. "Conversion" allows you to continue your coverage by purchasing a Whole life insurance policy (or universal life insurance policy for NY residents). Information regarding conversion will be provided by Aon or you can contact the CSC Benefits Center (managed by Aon Hewitt) at 877-627-4015	**Information regarding conversion will be provided by Aon.**
Matched Asset Plan (MAP): MAP participants may elect to either defer receipt of their account until a later date (but no longer than age 70 ½), or request a distribution of their account, or rollover their account to another tax deferred plan, such as a Rollover IRA. Please call your Retirement Coordinator if you have any questions about your MAP options. If you become totally and permanently disabled while employed by CSC and terminate from CSC as a result of your disability, you may apply to the CSC Retirement Plans Committee to receive the value of your MAP account, including your vested and unvested company contributions. The Committee requires that an attending physician's statement providing evidence of your permanent and total disability is attached to your application. No early withdrawal penalties apply.	**Not Applicable** **Applicable** The MAP Recordkeeper will send you information on how to take a distribution of your account within the next few weeks or you may contact the Recordkeeper via the MAP website (http://www.resources.hewitt.com/csc) or via the MAP Information Line (1.877.627.4015) If you choose to apply for a distribution based on total and permanent disability, call the MAP Information Line (1.877.627.4015) to discuss what is needed.
HSAs Post Termination: After termination of employment, YSA HSAs convert to Retail Accounts. Please contact CSC Benefits Center at 877-627-4015 for account balances.	All questions, concerns, and complaints should be directed to CSC Benefits Center (managed by Aon Hewitt) at 877-627-4015.
Long Term Disability: If you are currently receiving Long Term Disability benefits, you will continue to receive benefits per the terms of the policy. Benefits will continue as long as you are considered totally disabled by the terms of the policy up until age 65. (For those employees who are age 62 or older at the time of disablement, there is a schedule for the maximum benefit period. Please refer to your Employee Benefits Guidebook, or contact your Leave Coordinator for details.) The LTD policy has a provision such that the monthly benefit under the policy will be reduced by income that you receive from other sources such as Social Security, Workers' Compensation, and certain retirement benefits. Please refer to your Employee Benefits Guidebook for a detailed list. During the first 24 months you will be considered totally disabled under the policy if you are unable to perform the duties of your occupation. After 24 months, you will continue to be considered totally disabled if you are unable to engage in any substantially gainful occupation for which you are, or could be reasonably become, qualified by reason of education, training, or experience.	

aetna™

Aetna Life Insurance Company Service Center
P.O. Box 14548
Lexington, KY 40512-4548
Telephone Number: 1-800-523-5065
Fax Number: 1-800-238-6239

June 22, 2015

Recieved 10/5/16
From Laura

Loraine Boyne
6842 McFall Place
McLean, VA 22101

RE: Group Control: 838912
Employer: Computer Sciences Corporation
Employee: Loraine Boyne

Dear Ms. Boyne:

This letter is in response to your claim for the extension of your group life insurance coverage under the Permanent and Total Disability feature (Waiver of Premium) under the Computer Sciences Corporation benefit plan (the "Plan"). This Plan is funded by a policy of group life insurance issued by Aetna Life Insurance Company ("Aetna") to Computer Sciences Corporation 838912 (the "Policy").

We have completed our review of your claim for the Waiver of Premium benefit and have determined that the information received in support of this claim has not established that this loss falls within the Permanent and Total Disability coverage requirements of the Policy. Accordingly, the Waiver of Premium benefit has not been approved under the terms of the Policy.

In order to be entitled to the Waiver of Premium benefit under the Policy, certain requirements must be met. These requirements are found under the Permanent and Total Disability Coverage section of the Policy.

Under the terms of this provision, a covered employee who becomes permanently and totally disabled may continue, under certain conditions, to be covered under the group life insurance policy without making further contributions towards the coverage. This Permanent and Total Disability feature, which is more specifically described in your booklet-certificate, provides that:

"You will be considered permanently and totally disabled under this plan if disease or injury prevents you from:

- Working at your own job or any other job for pay or profit; and
- Being able to work at any reasonable job. A "reasonable job" is any job for pay or profit which you are, or may reasonably become, qualified for by education, training, or experience.

Qualifying for the Permanent and Total Disability Benefit
You must meet all of the following criteria to qualify for this benefit:

- You must be insured under this plan when you stop active work due to your disease or injury;
- You must be under age 60 when you stop active work; and
- You must be absent from active work for 6 consecutive months without interruption.

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Stopping active work means the date you are no longer physically at your job performing the duties of your job.

You must give Aetna a written notice of claim for this extended benefit. Aetna must receive your notice within 12 months from the date you stop active work. If your written notice is not received within 12 months of the date you stop active work, you will not be eligible for this benefit extension."

The information we reviewed for your request indicates that you do not satisfy the requirements for eligibility under the waiver of premium benefit because your permanent and total disability started on or after the date you attained age 60. This determination is based on the following information:

- Information reviewed in your Long Term Disability claim file
- Information reviewed in your Life Insurance claim file

Our records indicate that your date of birth is June 06, 1954 and the date you last worked was December 23, 2014. Since you attained age 60 on June 06, 2014 and stopped working at age 60, your eligibility for this benefit is denied.

For these reasons, we are unable to approve your request.

You may have the option to convert this coverage to an Individual Life Insurance policy by contacting your former employer within 31 days following the date of this letter. You may also call toll-free at 1-877-503-3448, to obtain a conversion application.

If you have any additional information, not previously submitted, which you believe will assist us in evaluating your claim for the Waiver of Premium benefit, please forward that to us for our consideration within one hundred eighty (180) days from the date of your receipt of this letter. In particular, the following information would assist us in further evaluating your claim for benefits and could affect our benefit determination:

- A certified copy of your birth certificate.
- Any additional medical information or records that would support a finding that you became permanently and totally disabled prior to your 60th birthday.
- Documentation that the Computer Sciences Corporation policy allows coverage to begin after age 60.
- Any other information or documentation you believe would assist us in reviewing your claim.

If you disagree with this determination of benefits, you have a right to a review of the decision and to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) if the denial is upheld on an appeal. Aetna Life Insurance Company will review any additional evidence you submit, including but not limited to:

- The specific information listed above, and
- Any other claim information or documentation you believe would assist us in reviewing your claim.

To obtain a review, you or your representative should submit a request in writing to this office. Your request should include the group name (e.g., employer), name of the insured, the insured's Social Security Number and the issues and comments and any documents, records or other information that you would like to have considered, whether or not submitted in connection with the initial claim. You may also receive, upon request free of charge, documents, records, and other information relevant to your claim. The written request for review must be mailed or delivered within 180 days

following receipt of this explanation. Ordinarily, you will receive notification of the final determination within 45 days following receipt of your request. If special circumstances require an extension of time, you will be notified of such extension during the 45 days following receipt of your request.

A copy of the Policy certificate will be provided to you upon written request. Request for any other Plan documents should be addressed to Computer Sciences Corporation.

To avoid delays when responding to this letter, please include the name and Social Security number of the covered person or deceased in all correspondence.

If you have any questions, please contact us at 1-800-523-5065.

Sincerely,

Lauren Swartz

Lauren Swartz
Claim Analyst
Premium Waiver Unit
Aetna Life Insurance Company

cc: Computer Sciences Corporation

verizon
Verizon Message Center

Tuesday, Oct 4 at 2:18 PM

From:"Herrick-Cardwell, Laura" <Laura.Herrick-Cardwell@csra.com>

To:"robert405@verizon.net" robert405@verizon.net

Subject:FW: Aetna denial for premium waiver for Loraine Boyne

HI Robert -

Please see the attached as well.

Thanks,
Laura

From: Herrick-Cardwell, Laura
Sent: Wednesday, September 14, 2016 10:52 AM
To: 'robert405@verizon.net' <robert405@verizon.net>
Subject: Aetna denial for premium waiver for Loraine Boyne

Robert -

Please see the attached. I think the reason for the denial was the fact she was over 60 years of age.
You have a phone # to call and to ask method this was sent out to Loraine.

Thanks.

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CSC Government Solutions LLC, A CSRA Company
15036 Conference Center Drive |Chantilly, Virginia 20151
Please note my new office telephone number and new email address.
w: +1.571.446.4070 | f: 866-594-7907|Laura.herrick-cardwell@csra.com | www.csra.com
Follow us on Facebook and Twitter
Enduring Values. Inspired Performance.

Lucas Kline

From: Robert Flick <robert405@verizon.net>
Sent: Tuesday, April 24, 2018 2:51 PM
To: Lucas Kline
Subject: Fwd: life insurance benefits for Loraine A Boyne

-----Original Message-----
From: Robert Flick <robert405@verizon.net>
To: benefits <benefits@csra.com>
Sent: Tue, Mar 13, 2018 11:29 am
Subject: life insurance benefits for Loraine A Boyne

Dear sir or madam,

My name is Robert Flick. I am the husband & the trustee to the estate of the late Loraine A Boyne who died August 28th 2016. Her birth date was June 6th 1954 & the last 4 digits of her ss# is 2779. My wife was an employee of CSC until her separation from the company on about January 20th 2016, having been on long term disability for about a year.

In early January of 2016 we received a separation packet from human resources of CSC that stated her request for a premium waver had been approved & no further action was needed by us. I followed up this letter with a phone call to hr CSC & was told again that was correct.

Within a couple weeks from her death I called hr CSC to report her death & to begin the claim process for her life insurance with Hartford life insurance co. Policy #GL-402775. The person I spoke with took some information & said they would call me back. Within a couple of days the person called back & informed me her life insurance policy had lapsed.

I have never received any formal letter or notice of denial of this claim.

My email address is is robert405@verizon.net. My new home address is 107 Deer Hill ct, Stephens City, va 22655.

Please process this claim with the insurance company as it does't appear to have ever been done, & send me a reply by email or letter.

Thank you for your attention to this matter,

Robert Flick

EXHIBIT 5

Lucas Kline

From: Robert Flick <robert405@verizon.net>
Sent: Tuesday, April 24, 2018 2:52 PM
To: Lucas Kline
Subject: Fwd: Automatic reply: life insurance benefits for Loraine A Boyne

-----Original Message-----
From: Robert Flick <robert405@verizon.net>
To: benefits <benefits@csra.com>
Sent: Thu, Apr 12, 2018 9:33 am
Subject: Fwd: Automatic reply: life insurance benefits for Loraine A Boyne

Dear Sir or madam,
On March 13, 2018 I sent you an email asking you to file the claim for my wife's, Loraine A Boyne, life insurance benefits with the Hartford life insurance company. To date I have no response from you or Hartford. Please give this matter your immediate attention.
thank you,
Robert P. Flick

-----Original Message-----
From: Benefits <Benefits@csra.com>
To: Robert Flick <robert405@verizon.net>
Sent: Tue, Mar 13, 2018 11:30 am
Subject: Automatic reply: life insurance benefits for Loraine A Boyne

Thank you for contacting the Benefits Mailbox.

For questions regarding your 2018 benefits coverage, please contact the CSRA Health and Wellness Service Center at 1-844-458-7430. You may also email your inquiry to CSRAhealthandwellness@willistowerswatson.com.

If your question is regarding your 401(k), please contact T. Rowe Price at 1-800-922-9945

Thank you,

The CSRA Benefits Team

EXHIBIT
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Lucas Kline

From: Robert Flick <robert405@verizon.net>
Sent: Tuesday, April 24, 2018 2:54 PM
To: Lucas Kline
Subject: Fwd: Automatic reply: Automatic reply: life insurance benefits for Loraine A Boyne

----Original Message----
From: Benefits <Benefits@csra.com>
To: Robert Flick <robert405@verizon.net>
Sent: Thu, Apr 12, 2018 9:34 am
Subject: Automatic reply: Automatic reply: life insurance benefits for Loraine A Boyne

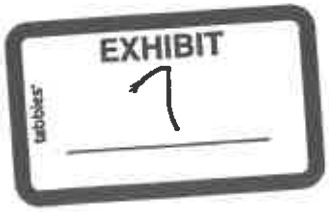
Thank you for contacting the Benefits Mailbox.

For questions regarding your 2018 benefits coverage, please contact the CSRA Health and Wellness Service Center at 1-844-458-7430. You may also email your inquiry to CSRAhealthandwellness@willistowerswatson.com.

If your question is regarding your 401(k), please contact T. Rowe Price at 1-800-922-9945

Thank you,

The CSRA Benefits Team

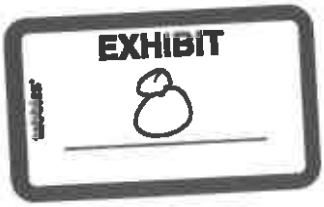


Lucas Kline

From: Robert Flick <robert405@verizon.net>
Sent: Wednesday, May 09, 2018 4:27 PM
To: Lucas Kline
Subject: Fwd: Loraine Boyne Life insurance

---Original Message---
From: Robert Flick <robert405@verizon.net>
To: benefits <benefits@csra.com>
Sent: Tue, May 1, 2018 11:29 am
Subject: Loraine Boyne Life insurance

Dear Sir or Madam,
I have sent you 2 emails requesting you process this claim. If I do not hear back from you in 7 days I will be filing a law suit.



Lucas Kline

From: Robert Flick <robert405@verizon.net>
Sent: Wednesday, May 09, 2018 4:26 PM
To: Lucas Kline
Subject: Fwd: Automatic reply: Loraine Boyne Life insurance

-----Original Message-----
From: Benefits <Benefits@csra.com>
To: Robert Flick <robert405@verizon.net>
Sent: Tue, May 1, 2018 11:29 am
Subject: Automatic reply: Loraine Boyne Life insurance

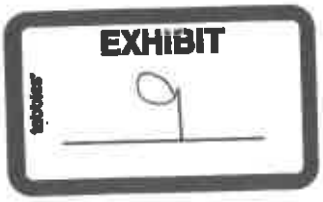
Thank you for contacting the Benefits Mailbox.

For questions regarding your 2018 benefits coverage, please contact the CSRA Health and Wellness Service Center at 1-844-458-7430. You may also email your inquiry to CSRAhealthandwellness@willistowerswatson.com.

If your question is regarding your 401(k), please contact T. Rowe Price at 1-800-922-9945

Thank you,

The CSRA Benefits Team



Lucas Kline

From: Robert Flick <robert405@verizon.net>
Sent: Saturday, August 25, 2018 12:31 PM
To: Lucas Kline
Subject: Fwd: life insurance benefits for Loraine A Boyne

-----Original Message-----
From: Robert Flick <robert405@verizon.net>
To: CSRAhealthandwellness <CSRAhealthandwellness@willistowerswatson.com>
Sent: Thu, Jun 28, 2018 5:03 pm
Subject: Fwd: life insurance benefits for Loraine A Boyne

-----Original Message-----
From: Robert Flick <robert405@verizon.net>
To: benefits <benefits@csra.com>
Sent: Tue, Mar 13, 2018 11:29 am
Subject: life insurance benefits for Loraine A Boyne

Dear sir or madam,

My name is Robert Flick. I am the husband & the trustee to the estate of the late Loraine A Boyne who died August 28th 2016. Her birth date was June 6th 1954 & the last 4 digits of her ss# is 2779. My wife was an employee of CSC until her separation from the company on about January 20th 2016, having been on long term disability for about a year.

In early January of 2016 we received a separation packet from human resources of CSC that stated her request for a premium waver had been approved & no further action was needed by us. I followed up this letter with a phone call to hr CSC & was told again that was correct.

Within a couple weeks from her death I called hr CSC to report her death & to begin the claim process for her life insurance with Hartford life insurance co. Policy #GL-402775. The person I spoke with took some information & said they would call me back. Within a couple of days the person called back & informed me her life insurance policy had lapsed.

I have never received any formal letter or notice of denial of this claim.

My email address is is robert405@verizon.net. My new home address is 107 Deer Hill ct, Stephens City, va 22655.

Please process this claim with the insurance company as it does't appear to have ever been done, & send me a reply by email or letter.

Thank you for your attention to this matter,

Robert Flick

EXHIBIT 10

Lucas Kline

From: Robert Flick <robert405@verizon.net>
Sent: Saturday, August 25, 2018 12:30 PM
To: Lucas Kline
Subject: Fwd: Life insurance benifits

---Original Message---
From: Mayweather, Shavon (Buffalo) (Buffalo) <Shavon.Mayweather@liazon.com>
To: robert405 <robert405@verizon.net>
Sent: Thu, Jun 28, 2018 7:57 pm
Subject: Life insurance benifits

Hello Robert ,

Thank you for contacting your CSRA Health and Wellness support team. We have received your inquiry regarding the life insurance benefit for your spouse.

We are the new third party benefits administrator for 2018 and have no information on your group prior to that so unfortunately we will have to refer you back to CSRA for assistance with your inquiry.

You can contact the HR Benefits Team at CSRA via email at benefits@csra.com. Please disregard the auto-reply email you receive advising to contact us at the support center as this is something that would need to be addressed by CSRA directly.

Please let me know if you have any additional questions.

Thank you,

Shavon Mayweather
Liazon

866-542-9661 (Office)
888-810-1095 (Fax)
Shavon.Mayweather@liazon.com

www.liazon.com

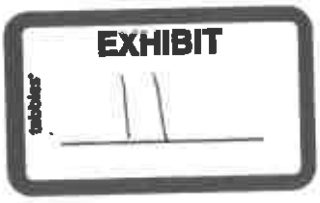


EXHIBIT 12

Lucas Kline

From:	Lucas Kline
Sent:	Tuesday, November 13, 2018 1:44 PM
To:	'benefits@csra.com'
Cc:	'robert1405@verizon.net'
Subject:	Claim for Loraine Boyne life insurance benefits

I represent Mr. Robert Flick. Robert Flick is the widower of Loraine Boyne. Loraine Boyne, deceased, was a senior manager employed by Computer Sciences Corporation "CSC" for many years until her termination in January, 2016. Effective November 30, 2015, the former North American Public Sector business division of CSC split off and merged with SRA International, Inc., to form the independent company CSRA, Inc. As part of her employment agreement with CSC/CSRA (the "Company"), the Company agreed to provide Ms. Boyne certain employee benefits, among them a life insurance benefit by which the Company would pay for life insurance for Ms. Boyne under the terms of a group life insurance policy. The Company sponsored the CSC Group Insurance Plans, which included life insurance benefits underwritten by Aetna Life Insurance Company of Hartford. The Company also sponsored the CSRA Inc. Fully-Insured Employee Welfare Benefits Plan, which included life insurance benefits underwritten by Hartford Life and Accident Insurance Company. By agreeing to provide the life insurance benefit under these policies, the Company agreed to provide Ms. Boyne with the ability to continue life insurance coverage after any termination of her employment, subject to the terms of the policies permitting coverage continuation (and subject to Ms. Boyne's eligibility under the terms of those policies to continue coverage). During her time working for the Company, Ms. Boyne elected to utilize the employee life insurance benefit, and participated as a named insured under the Hartford policy. Ms. Boyne also elected to utilize the benefit of paying an additional premium under the Aetna policy for a supplemental life insurance benefit. The Company paid the premium on the policy for Ms. Boyne's base life insurance coverage, and deducted the premium for Ms. Boyne's supplemental life insurance coverage from her paychecks. Ms. Boyne's base life insurance coverage was one times her annual salary. Her supplemental life insurance coverage was an additional two times her annual salary. Her annual salary was approximately $149,000.00. Mr. Flick was the sole beneficiary of Ms. Boyne's life insurance. In January 2016, Ms. Boyne had been on long-term disability for a year, and in accordance with the Company's employment policies, she was terminated as an employee. In the fall of 2015, knowing that she would be terminated after she had been on long-term disability for a year, Ms. Boyne inquired with the Company about maintaining her life insurance coverage after her termination, and was told that it would be maintained.

The Hartford policy had three options for continuing coverage after termination. The first option was known as "Waiver of Premium." Under this provision, an employee who was disabled and who qualified for Waiver of Premium had the right to continue coverage without paying a premium. The amount of continued coverage was the amount in force on the date the individual ceased to be an active employee. The Hartford policy had eligibility requirements for this Waiver of Premium option, including the requirement that the insured was less than 60 years old when he/she became disabled. The second option was "Portability." The Hartford policy allowed an employee to continue coverage after termination by submitting a portability application within 31 days of termination and continuing to pay the premium. The third option was "Conversion." The Hartford policy allowed an employee to continue coverage after termination by applying to the insurer for an individual life insurance policy called a "conversion policy," and the individual had to pay the premiums. The application had to be completed within 31 days of the employee's termination. The Hartford policy also provided that an employee could not apply for the Portability or Conversion options if they had elected the Waiver of Premium option and were eligible. The Hartford policy stated that if the Waiver of Premium option was denied due to lack of eligibility, the individual could then continue coverage under the Portability benefit or convert coverage using the Conversion benefit. The Aetna policy did not have a "Waiver of Premium" option for continuing coverage, but did have portability ad conversion options.

As part of the termination process, the Company sent Ms. Boyne a document, dated January 15, 2016, and titled "Your Benefits Upon Termination of Employment After a 12-Month Leave of Absence". The termination date was identified as

January 23, 2016. The document stated that, in regard to Ms. Boyne's Employee Basic Life Insurance Coverage: "Carrier has approved your Waiver of Premium Request for Basic Life coverage (No action is required from you for your Basic Life coverage." This document confirmed what Ms. Boyne had been told by the Company when she inquired about continuing her life insurance coverage after termination: namely, that it would be maintained. Based upon the fact that the Company, not Ms. Boyne, had administered the policy, Ms. Boyne and Mr. Flick reasonably relied on the Company's representation in the January 15, 2016 document, and did not contact the life insurer directly to confirm the information in that document that "Carrier has approved your Waiver of Premium Request for Basic Life coverage." In reliance on this representation from the Company, Ms. Boyne and Mr. Flick took no action to pursue the Portability or Conversion options for continuing Ms. Boyne's life insurance coverages after her termination. They also did not pay premiums on the policies. They reasonably believed, based on the representation from the Company, that the policies were continued. After Ms. Boyne passed away on August 28, 2016, Mr. Flick, on behalf of her Estate and as beneficiary of the policy, contacted the Company to determine how to claim Ms. Boyne's life insurance benefit. He was directed to Aetna Life Insurance Company. Aetna then informed Mr. Flick that Ms. Boyne did not qualify for the Waiver of Premium provision because she was over 60 years old when she became disabled. The life insurance benefit under the policy was not paid. Mr. Flick has subsequently learned that (unlike the Hartford policy) the Aetna policy did not have a Waiver of Premium provision, so it is unclear as to whether Aetna's response related to the Hartford policy or the Aetna policy. In any case, had Mr. Flick and Ms. Boyne known that Ms. Boyne did not qualify for the Waiver of Premium provision under the Hartford policy, Ms. Boyne would have instead submitted a portability or conversion application under the Hartford and Aetna policies in order to continue her coverage after her termination. Had Ms. Boyne submitted a portability or conversion application under the Hartford or Aetna policies, she would have been eligible for continuation of her coverage.

Mr. Flick filed suit against the Company in Fairfax County Virginia on August 15, 2017. The case was removed to this Court then dismissed without prejudice by order of this Court on December 5, 2017 due to pre-emption by ERISA and failure to exhaust administrative remedies.

In early 2018, Mr. Flick made several calls to attempt to learn how to submit a claim for life insurance benefits under the Hartford policy. On February 5, 2018, he called Hartford, and was told the policy was active, but was a group policy and Hartford did not have records for individuals, so the Company had to initiate the claim. On February 12, 2018, he called the Company's benefits hotline and spoke to a representative who took information and told him she would open a claim and call Mr. Flick back, but he never heard back. On March 1, 2018, he called the Company's benefits hotline and spoke to a representative who took information and told Mr. Flick she would call him back, but he never heard back. On March 6, 2018, he called the Company's benefits hotline and spoke to a representative who took information and told Mr. Flick that he needed to send an email to the Company's Benefits department. On March 18, 2018, as directed in the last call, he sent an email to the Benefits department of the Company regarding the claim on Ms. Boyne's life insurance policy. Mr. Flick received an automated response and then followed up on April 12, 2018. He received another automated response. On May 1, 2018, Mr. Flick sent another follow-up email. He received another automated response. On June 28, 2018, Mr. Flick then sent the same email from March 18, 2018 to the CSRAhealthandwellness@willistowerswatson.com email address contained in the automatic replies from the Company, and received an email referring him back to the Company email address.

None of Mr. Flick's calls or emails have resulted in a substantive response from the Company. The Company has not directed Mr. Flick to an administrative claims process to submit a claim for benefits under the policy or to appeal an adverse decision. Mr. Flick requests that the Company submit a claim to Hartford for benefits due to Ms. Boyne under the group life insurance policy, and if a claim has not been made under the Aetna policy, requests that such a claim be made. Mr. Flick further states that he would like to avail himself of any Company administrative procedure to challenge the non-payment of benefits by Aetna under either the Aetna or Hartford policy, policy due to the Company's statement on January 15, 2016 that "Carrier has approved your Waiver of Premium Request for Basic Life coverage." Please contact me with any questions.

Best regards,
Lucas Kline

Lucas J. Kline
Associate Attorney
Main: 703-591-4900
Direct: 703-592-8567
Fax: 703-591-5082
lkline@haleball.com
www.haleball.com

Hale & Ball
Carlson Baumgartner Murphy PC

Lucas Kline

From: Benefits <Benefits@csra.com>
Sent: Tuesday, November 13, 2018 1:44 PM
To: Lucas Kline
Subject: Automatic reply: Claim for Loraine Boyne life insurance benefits

Note: This message has changed. Please read in its entirety.
REMINDER: Annual Enrollment is being held from November 14 – 30. You must take action if you want benefits through CSRA/GDIT for 2019.

Thank you for contacting the Benefits Mailbox. Your issue/question is important to GDIT and we want to make sure you get the proper assistance. However, please note that this mailbox is for Health and Welfare benefit escalation issues only. Health and Welfare benefits include:

- Medical, Dental and Vision (for Actives, Terms, and Retirees)
- Money Accounts (HSA, HRA, FSA, Commuter)
- Life and Disability
- Other Voluntary Benefits

If you have not already done so, please contact the **Health & Wellness Service Center at 1-844-458-7430** or CSRAhealthandwellness@willistowerswatson.com for assistance with your issue.

If you have already contacted the Service Center and they were unable to address your issue, a member of the Benefits Team will review your email and provide a response **as soon as possible.**

Please be assured that this mailbox is monitored daily. To avoid adding to the backlog, we request that you refrain from submitting additional emails following-up on your initial email.

Thank you,
The CSRA/GDIT Benefits Team

Points of Contact for Other Popular Topics

- **401(k)** - T. Rowe Price Plan Service Center, 1-800-922-9945
- **Pension** - CSRA Pension Center, 1-844-335-9041
- **Payroll and Tax** - Central_Payroll@csra.com
- **SCA Health & Welfare Stipends** - Compensation@csra.com
- **Tuition Reimbursement/Educational Assistance** - EducationalAssistance@csra.com
- **Address and Name Changes** - Open a support case with 411 at 1-844-380-3411 or https://my.csra.com/csrahelp
- **Time Away From Work**
  - Leave Policy for employees not covered by a CBA or SCA can be found here
  - Leave Policy for employees covered by a CBA or SCA can be found here

EXHIBIT 13

- For all other inquiries, open a support case with 411 at 1-844-380-3411 or https://my.csra.com/csrahelp
- For Escalations where a support case has already been opened, contact WellWithin@csra.com